St. Francis Hospital[1] ***and*** **International Brotherhood of Electrical Workers, Local Union No. 474, AFL-CIO, Petitioner.** Case 26-RC-6109

December 16, 1982

DECISION ON REVIEW AND DIRECTION

On November 5, 1979, following a hearing held before Hearing Office Timothy J. O'Leary to determine whether the employees in the petitioned-for unit constituted an appropriate unit for bargaining, the Regional Director for Region 26 issued his Decision and Direction of Election in the above-entitled proceeding. He found appropriate a unit consisting of all the Employer's maintenance employees, including several employee classifications not encompassed in the Petitioner's proposed unit,[2] and rejected the Employer's proposed inclusion of all its service and maintenance employees. He directed that an election take place among the employees in said unit.

Thereafter, in accordance with Section 102.67 of the National Labor Relations Board Rules and Regulations, Series 8, as amended, the Employer filed a timely request for review alleging that the Regional Director erred in his findings. On December 4, 1979, the National Labor Relations Board by telegraphic order granted the Employer's request for review. Thereafter, the Petitioner filed a brief on review. Subsequently each of the parties also filed statements of position.

The Board has considered the entire record in this case, with respect to the issues under review, including the various briefs filed by the parties, and makes the following findings:

The Employer operates a 529-bed hospital in Memphis, Tennessee. The hospital employs approximately 1,300 employees. There are approximately 39 employees in the maintenance classifications and approximately 438 employees in the combined service and maintenance categories.

The maintenance employees are grouped in 4 of the Employer's 90 departments: mechanical and maintenance, building maintenance, grounds maintenance, and boiler plant operations. The employees working in these four departments include six general maintenance mechanics, one electronics technician, two carpenters, two painters, one plumber, three electricians, six boiler operators, one painter/vinyl hanger, one X-ray processor mechanic, two cabinetmakers, one pneumatic tube mechanic, one utility operator, one refrigeration mechanic, two communication technicians, one HVAC mechanic, one HVAC trainee/helper, one utility mechanic, two maintenance helpers, one groundskeeper, and three refuse and linen collectors. While most of these employees spend the majority of their time making on-location repairs throughout the hospital, they are supervised separately from other employees and receive their daily work assignments only from their department supervisors.

Maintenance employees possess specialized skills and experience. The Employer provides both on-the-job training and formal technical courses designed to enhance these skills. Reflective of their greater skills is the fact that maintenance employees' wages are concentrated in the higher ranges of the Employer's service and maintenance pay plan.

Relying on these attributes and the Board's decision in *Allegheny General Hospital*,[3] the Regional Director found that the maintenance departments constituted a well-defined complement of employees, possessing a community of interest sufficiently separate from the service department workers to warrant their separate bargaining unit status. However, the Employer asserts that a unit encompassing both service and maintenance employees is more appropriate. The Employer contends that the courts have rejected the unit approach of *Allegheny General, supra*, and that legislative history and the language of the 1974 health care amendments to the National Labor Relations Act[4] support its view.

In *Allegheny General, supra*, the majority opinion outlined, in great detail, the legislative history of the 1974 health care amendments and concluded that Congress never intended to preclude the Board's use of traditional community-of-interest criteria in determining health care employee units. We announced that community-of-interest standards, as set forth in *American Cyanamid Company*,[5] would be applied to health care maintenance employee unit determinations. *American Cyanamid* did not involve a health care employer, but rather dealt with the factors tending to establish that the maintenance employees therein had demonstrated a

[1] The Board was informed that on February 29, 1980, by action of the Employer's board of directors, the name of the Employer was changed from St. Joseph Hospital East, Inc., to St. Francis Hospital.

[2] The unit found appropriate consisted of:

All maintenance employees, including communications technicians, painters, carpenters, maintenance helpers, x-ray processor mechanic, refuse and linen collectors, utility operators, cabinet makers, painter/vinyl hanger, HVAC trainee, HVAC mechanic, boiler operators, electronics technicians, electricians, general maintenance mechanics, pneumatic tube mechanic, groundskeeper, utility mechanic, refrigeration mechanic, and plumber employed by the Employer at its hospital at 5959 Park Avenue, Memphis, Tennessee, excluding all other employees, including office clerical employees, Bio-medical Engineering Department employees, service employees, guards and supervisors as defined in the Act.

[3] 239 NLRB 872 (1978), enforcement denied 608 F.2d 965 (3d Cir. 1979).

[4] Public Law 93-360, 93d Cong., S3203, 88 Stat. 395.

[5] 131 NLRB 909 (1961).

distinct community of interest sufficient to warrant their own bargaining unit, separate from the production employees; i.e., level of skills; amount of work integration with production employees; degree of interchange between production and maintenance departments; degree of shared supervision; and location of the maintenance department. Applying these factors to the factual setting in *Allegheny General*, the Board found that the maintenance employees at that hospital should be granted their own unit.

However, upon the hospital-Employer's petition for review of that decision the Third Circuit Court denied enforcement. The court held that the Board's analysis failed to comply with earlier hospital unit cases in which the court stated that: (1) The Board is precluded under the National Labor Relations Act from extending comity to a unit certification granted by a state labor relations authority;[6] (2) the legislative history of the 1974 health care amendments prohibits the Board from finding appropriate separate units of maintenance and powerhouse employees at health care institutions;[7] and (3) the 1974 amendments also preclude the Board from relying on its traditional community-of-interest criteria in making unit determinations in the health care industry.[8] The court criticized the Board's apparent disregard for the role of judicial review in the development of labor policy through statutory interpretation and reiterated its adherence to the position that health care cases require a unit determination standard different from non-health care cases.

In effect the court told the Board that it has an obligation to enunciate a workable health care maintenance unit determination test in which the long-established community-of-interest criteria are balanced against the legislative concern about overproliferation of health care bargaining units. Something more specific than a mere verbal acknowledgement that we have considered the legislative history in reaching our decisions is required.

While we attempted in *Allegheny General* to accomplish this, we now realize that our decision in that case was imprecise and, therefore, susceptible to misinterpretation concerning how we reached the conclusion that the maintenance employees there warranted their own bargaining unit, thus justifying that court's criticisms. For these reasons we shall attempt in this case to outline the procedure we follow in determining the appropriateness of maintenance employee bargaining units in the health care field. In describing this process it is impossible to ignore other health care employee bargaining units, for the analytical scheme in unit determinations necessarily encompasses all health care employees. It is important to begin this explanation with a brief review of the legislative history of the amendments which lies at the heart of the controversy surrounding the appropriateness of various health care bargaining units.

The issue of whether or not Congress intended to permit maintenance employees to be represented in their own unit arises from a single reference in the committee reports accompanying the legislation and a few statements made by sponsors of the amendments. Both the Senate and the House committee reports contain the following statement:

> Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB [403] (1974), and *Woodland Park Hospital*, 205 NLRB [888] (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB [1232] (1973).[1]

[1] By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.[9]

In each of the cases cited "with approval" the Board had refused to certify petitioned-for bargaining units on the basis that those units failed to exhibit a community of interest, separate and apart from all other employee groups, sufficient to warrant their own unit.[10] The principle for which these cases stand is that fragmented bargaining units should be avoided. Congress' citing them reflects its concern that the greater the number of units, the greater the possibility that the operation of the facility could be interrupted. The threat that some small unit of striking hospital employees could effectively shut down the facility's ability to meet the needs of its patients was seen as the potential consequence of unit multiplicity.

Senator Taft was particularly concerned about this possibility, prompting him to introduce S. 2292

[6] *Memorial Hospital of Roxborough* v. *N.L.R.B.*, 545 F.2d 351 (3d Cir. 1976).

[7] *St. Vincent's Hospital* v. *N.L.R.B.*, 567 F.2d 588 (3d Cir. 1977).

[8] The Ninth Circuit apparently agrees with this interpretation of the amendments. See *N.L.R.B.* v. *St. Francis Hospital of Lynwood*, 601 F.2d 404 (9th Cir. 1979); *N.L.R.B.* v. *HMO International/California Medical Group Health Plan*, 678 F.2d 806 (9th Cir. 1982).

[9] S. Rept. 93-766, 93d Cong., 2d sess. 5 (1974), "Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974" at 12; H. Rept. 93-1501, 93d Cong., 2d sess. 6-7 (1974), at 274-275. Hereafter this shall be referred to as Legislative History.

[10] The only case dealing specifically with maintenance employees is *Four Seasons Nursing Center of Joliet*, 208 NLRB 403 (1974). In that case the entire maintenance staff consisted of two unskilled employees who performed routine repair work and who shared common tasks and supervision with the housekeeping employees.

which would have amended Section 9(b) of the Act[11] by limiting the number of health care bargaining units to four, as follows:

> [T]he Board shall not decide that any unit in a health care institution is appropriate for the purposes of collective bargaining which (i) includes professional employees unless all of the professional employees employed by such institution are included therein; or (ii) includes technical employees (as defined from time to time by the Board) unless all of the technical employees employed by such institution are included therein; (iii) includes clerical employees unless all of the clerical employees employed by such institution are included therein; or (iv) includes service and maintenance employees—which shall be defined to include all employees except (A) professional, technical, and clerical employees and (B) any individual employed as a guard . . . unless all of the service and maintenance employees employed by such institution are included therein.[12]

However, when this proposal was not approved by the committee, Senator Taft endorsed the committee report language, quoted above, and stated that the Board should be permitted flexibility, yet exercise caution, in unit determinations so as to avoid disruptions resulting from jurisdictional disputes and work stoppages.

Senator Williams expressed faith in the Board's judgment in establishing appropriate collective-bargaining units, particularly in newly covered industries. He noted that, while the Board generally avoids unnecessary proliferation of units, sometimes circumstances, e.g., area practice, disparity of employee interests, etc., require that there be multiple bargaining units of employees of a single employer. He added, "While the committee clearly intends that the Board give due consideration to its admonition to avoid an undue proliferation of units in the health care industry, it did not within this framework intend to preclude the Board acting in the public interest from exercising its specialized experience and expert knowledge in determining appropriate bargaining units."[13]

Congressman Thompson agreed with this view, pointing out that the committee was concerned about the *undue* proliferation of health care employee units. He stated that the reference to the three Board decisions in the committee report was intended to reflect the statutory mandates, not to foreclose the Board's discretion in determining traditional craft and departmental units in the health care field.[14]

Nowhere in the language of the amendments, in the accompanying committee and conference reports, or in the debates within the Senate or House, are the words "maintenance units" found. The only arguable support for the position that maintenance units were intended to be barred throughout the health care industry is the favorable reference to *Four Seasons, supra*, in the committee reports. However, as indicated above, that case's extreme factual setting makes it unlikely that this bare reference, without more, was intended as an absolute proscription against health care maintenance units of any kind. Had it been Congress' intent to proscribe health care maintenance units, it could simply have incorporated into the amendments a specific provision to that effect or stated this purpose outright within the Legislative History. This was not done. Moreover, Senator Taft's bill, which would have, *inter alia*, accomplished this result, was rejected in part because the unit provisions were considered too inflexible.

The Legislative History reveals that Congress' purpose in enacting the health care amendments was to extend to health care employees the organizational rights and protections afforded by the Act. The changes in the Act needed to accomplish this result were minimal and the restrictions placed on the Board's processes, at least with regard to its unit determination functions, were limited to a cautionary instruction in the Legislative History that undue proliferation is to be avoided.

A review of some unit determination cases reveals how the Board has attempted to follow both the letter of the law as well as its intent. In *Madeira Nursing Center*,[15] decided 18 months prior to passage of the amendments, the Board concluded that licensed practical nurses (LPNs) were entitled to be represented separately at proprietary health care institutions. This decision was based on expert testimony which demonstrated a prevailing nationwide pattern of separate representation for LPNs.[16] However, in its first post-amendment decision involving the question of separate representation for LPNs, *St. Catherine's Hospital*,[17] the Board effectively overruled *Madeira* and held that henceforth the smallest appropriate unit which

[11] Sec. 9(b) of the Act reads in pertinent part: "The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof . . . ."

[12] Leg. Hist., *supra* at 108–109.

[13] 120 Cong. Rec. S. 12104 (1974), Leg. Hist., *supra* at 363.

[14] 120 Cong. Rec. E4899 (daily ed., July 2, 1974).

[15] *Madeira Nursing Center, Inc.*, 203 NLRB 323 (1973).

[16] *Id.* at 324–325.

[17] *St. Catherine's Hospital of Dominican Sisters of Kenosha, Wisconsin, Inc.*, 217 NLRB 787 (1975).

could encompass LPNs would be a unit of all technical employees.[18]

In *Kaiser Foundation Hospitals*,[19] the first post-amendment case dealing with separate representation for pharmacists, the Regional Director concluded that the pharmacists constituted a separate appropriate unit because they were "physically isolated" from and had "virtually no contact or interchange" with other employees, had separate supervision, and could not substitute for other employees given their "very specific training." While not disputing these findings, the Board nevertheless determined that a separate unit of pharmacists was inconsistent with the Legislative History's concern with unit fragmentation.

In fact, among the many health care professional employees, only registered nurses (RNs)[20] and physicians[21] have been regularly granted separate units, apart from other health care professional employees. However, it should be emphasized that simply because we have found that certain unique attributes generally distinguish RNs and physicians sufficiently from other health care professionals to warrant separate representation, this does not mean that they will invariably be entitled to their own units.[22] The *per se* approach was specifically rejected in *Newton-Wellesley Hospital, supra*. In that case the Board disavowed its earlier presumption that RN-only units were appropriate, finding such an approach to be at odds with its Section 9(b) responsibility to "decide in each case" whether the requested unit is appropriate. In *Newton-Wellesley* we found that the requested unit of RNs was appropriate, noting particularly their administrative and functional separation from other employees, their continuous and close working contact with one another, and the unique educational and training requisites of the profession.[23] Since enunciating this case-by-case approach to RN units in *Newton-Wellesley*, the Board has required that the record demonstrate the appropriateness of the requested unit, rather than presume that this quality exists by virtue of the RN designation.[24]

On the same day that the *Kaiser* decision issued, the Board declined, in *Levine Hospital of Hayward, Inc.*,[25] to give a group of residual employees—a classic appropriate unit in non-health care cases—their own bargaining unit. The possibility that these employees could be included within a unit of already-represented service and maintenance employees, should an interested party properly so petition, was viewed as an adequate safeguard for these employees' representational rights when weighed against the unit considerations raised in the Legislative History.

The most explicit evidence that the Board does not adhere to traditional unit criteria in health care unit determinations is our decision in *Duke University*.[26] There we stated that the employees covered by the petition—switchboard operators who are separately housed, had no day-to-day contact with other employees, worked different hours and under separate supervision—shared a distinct community of interest, but that such a unit was "Congressionally foreclosed."[27]

Business office clerical employees aregenerally recognized as possessing such distinct job characteristics as to warrant representation in their own unit both inside and outside the health care field. See *Mercy Hospitals of Sacramento, Inc.*, 217 NLRB 765 (1975); *Sisters of St. Joseph of Peace*, 217 NLRB 797 (1975). So too have we acknowledged that employees included under the "service and maintenance" rubric usually are appropriately separated from other health care employees, either in an overall category[28] or within a separate mainte-

[18] The nature of the functions performed in modern health care facilities has led to the inclusion of a wide variety of specially trained employees within the technical employee category. See, e.g., *Clarion Osteopathic Community Hospital*, 219 NLRB 248 (1975); *Nathan and Miriam Barnert Memorial Hospital Association d/b/a Barnert Memorial Hospital Center*, 217 NLRB 775 (1975); *Pontiac Osteopathic Hospital*, 227 NLRB 1706 (1977); *Children's Hospital of Pittsburgh*, 222 NLRB 588 (1976). While many individual differences exist among the diverse specialities found in these cases, the Board has focused on broader, unifying characteristics, such as the necessity of training and certification rather than the type of training, in grouping these employees within a single bargaining unit.

[19] 219 NLRB 325 (1975).

[20] *Newton-Wellesley Hospital*, 250 NLRB 409 (1980).

[21] *Ohio Valley Hospital Association*, 230 NLRB 604 (1977).

[22] A correlative issue of preventing disunity within subcategories of professional health care employees led to a Board majority's decision to deny a separate unit for nursing school instructors, exclusive of hospital-based RNs, in *Jersey Shore Medical Center-Fitkin Hospital*, 225 NLRB 1191 (1976). In that case differences in supervision, duties, location, and hours—factors which likely would have been adequate to find a separate community of interest in a non-health care setting—were subordinated to the overriding interest of avoiding unit proliferation.

Similarly, the separate community-of-interest factors exhibited by clinical psychiatrists were subordinated in favor of professional cohesion in *New York University Medical Center, a Division of New York University*, 217 NLRB 522 (1975).

[23] As these criteria indicate, and as the decision in *Newton-Wellesley* makes clear, the unit determination analysis necessarily includes aspects of both intraunit similarities and interunit differences; i.e., the "community of interest" factors shared by those within the proposed unit as well as the "disparity of interests" which distinguish these employees from those outside the unit description.

[24] See *Mount Airy Foundation d/b/a Mount Airy Psychiatric Center*, 253 NLRB 1003 (1981); *Milwaukee Children's Hospital Association*, 255 NLRB 1009 (1981). Accordingly, we disavow the footnote reference in *French Hospital Medical Center*, 254 NLRB 711, fn. 7 (1981), that *Newton-Wellesley* held such units were presumptively appropriate.

[25] 219 NLRB 327 (1975).

[26] 217 NLRB 799 (1975).

[27] As we indicated in *Newton-Wellesley Hospital, supra*, the examples of cases in which the Board, since passage of the amendments, has departed from the community-of-interest analysis regularly followed in non-health care cases extend far beyond those cited here. See 250 NLRB at fn. 16.

[28] There are no reported Board decisions in which an election limited to a health care institution's service employees was directed. However, the appropriateness of a separate service unit is inferential in the event that a maintenance unit is recognized or certified.

nance unit, depending upon the circumstances presented in a particular case.

These cases demonstrate that the Board has responded to the Congressional concern for special attention to the number of bargaining units at a health care institution. It has refined and limited the traditional unit principles applicable in other employment settings. In cases arising outside the health care industry, the Board applies only a community-of-interest test, in which we examine the petitioned-for unit for shared job characteristics and common workplace concerns to determine whether that group of employees comprises an appropriate unit for bargaining. However, in the health care industry, to guard against the possibility that each of the many subspecialties at a modern health care facility might seek a separate bargaining unit, we have added a preliminary step to our unit determination process. We have identified certain groups of employees commonly found in a health care institution: physicians, registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees, and skilled maintenance employees. Often these groups of employees constitute the entire employee complement, and, almost invariably, all employees will fall into one of these enumerated categories. Based on our experience in examining the employee complement at health care facilities, we have determined that these seven named classifications represent the groupings of employees that *may* constitute appropriate units for bargaining. Only after determining that the unit sought fits one of these classifications do we then apply our traditional unit principles to determine whether the specific employees involved do, in fact, display the requisite community of interest to warrant separate representation. Under this two-tiered approach, if a petitioner seeks to represent a unit comprised of one of these seven potentially appropriate units, we will analyze the proposed unit to determine whether it displays the requisite separate identity for individual representation. If, however, a petitioner seeks to represent a unit of employees smaller than one of these seven identified groups, for example, a unit consisting only of physical therapists or telephone operators, we will dismiss that petition before reaching the second stage of analysis, unless we are presented with extraordinary and compelling facts justifying allowance of a smaller unit. By restricting the number of potentially appropriate units in this way—despite the fact that many more units could be appropriate under our traditional community-of-interest analysis alone—we have met our statutory responsibility to ensure against unwarranted fragmentation of bargaining units in the health care industry.

Our dissenting colleagues have seized upon the term "community of interest" as evidence that we have ignored congressional intent and disobeyed judicial directives[29] that we modify our unit determination approach to meet the special needs of the health care field. They contend that use of a disparity-of-interest test instead will comply with Congress' directives and, therein, respond to the courts' concerns regarding unit proliferation. We believe their position is misdirected in several important respects. First, Congress did not instruct the Board to abandon its community-of-interest test in health care cases. Instead, as described at length above, the Legislative History relating to this issue expressly reaffirms Congress' faith in the Board's long-established processes and demonstrated expertise in performing its unit-determination function. In addition, Congress left intact Section 9(b) of the Act, which imposes upon the Board the responsibility to "decide in each case, whether in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for collective bargaining shall be the employee unit, craft unit, plant unit or subdivision thereof." Consistent with this 9(b) mandate, the Board's practice of over 40 years (at the time of the adoption of the health care amendments) had been to begin its review of appropriate bargaining units by examining the appropriateness of the petitioned-for unit. Had Congress intended to alter radically this procedure, it would have stated this

[29] In support of its position, the dissents cite circuit court criticism of the Board's health care unit approach. Notably, the courts have been most critical of decisions dealing with maintenance units and RN units. See discussion of *Allegheny General, supra*. The Ninth Circuit, in *St. Francis Hospital of Lynwood, supra*, attached the Board's *per se* approach to RN unit appropriateness, a policy which we subsequently disavowed in *Newton-Wellesley, supra*. See also the Tenth Circuit Court of Appeals opinions in *Presbyterian/St. Luke's Medical Center* v. *N.L.R.B.*, 653 F.2d 450 (1981), *Beth Israel Hospital and Geriatric Center* v. *N.L.R.B.*, 677 F.2d 1343 (1981), and *St. Anthony Hospital Systems* v. *N.L.R.B.*, 655 F.2d 1028 (1981). The latter two cases were reaffirmed *en banc* 688 F.2d 697 (10th Cir. 1982). September 13, 1982. Additionally, in *St. Francis*, the court charged that the Board's adherence to a "community of interests" test rather than a "disparity of interests" test violated the congressionally advised approach to health care cases. This criticism is unwarranted, given our evaluation of the disparities element within the community-of- interest formula. See fn. 22, *supra*, and further discussion of this issue, *infra*. In *HMO International, supra*, the Ninth Circuit went even further; it not only rejected the Board's rationale for finding an RN-only unit appropriate, but also—without any support from the statute or the Legislative History—disrupted an existing technical employee unit. With but a passing reference to *Sonotone (Sonotone Corporation)*, 90 NLRB 1236 (1950), and Sec. 9(b)(1), the court stated that LPNs included within an existing technical employee unit more closely resemble the RNs in issue and that these two groups should properly be represented within the same unit. We believe that while the HMO decision represents the most extreme example of misinterpretation of the Legislative History to the health care amendments, it is the inevitable result of placing more importance upon a congressional admonition than upon sound principles of statutory construction.

intent; Congress having remained silent on this issue, we rely on the doctrine of legislative reenactment to find that Congress intended no such drastic change.[30] Congress directed only an adjustment in the manner in which we apply the unit concept to the health care industry. We believe the approach outlined above—adding a preliminary "screening" step to our unit determination process—accords with Congress' intent.

Further, the approach of the dissents—to apply a disparity-of-interest test in such a way as to derive the *most* appropriate unit—is contrary to the Act and long-established Board law and is totally lacking in support from the Legislative History to the amendments. This Board has never held to so narrow and precise a view of bargaining unit composition. As stated in *Morand Brothers Beverage Company, et al.*:[31]

> There is nothing in the statute which requires that the unit for bargaining be the *only* appropriate unit, or the *ultimate* unit, or the *most* appropriate unit; the Act requires only that the unit be "appropriate."[13] It must be appropriate to ensure to employees, *in each case*, "the fullest freedom in exercising the rights guaranteed by this Act."[14]

[13] Appropriate is a word with a well-defined meaning. Webster's International Dictionary defines it as: "Suitable for the purpose and circumstances; befitting the place or occasion." It carries with it no overtones of the exclusive or the ultimate or the superlative. To convey such thoughts, the words "only" or "ultimate" or "most" must be conjoined with the word "appropriate." The statute does not conjoin them. See also *Garden State Hoisery Co.*, 74 NLRB 318, 324.

[14] Section 9(b).

As this passage affirms, our responsibility is to determine unit composition that is suited for the collective-bargaining purposes in which the particular employees are situated. It need be neither the broadest possible group nor the narrowest, but it *must* ensure effective representation for the employees included within the unit.[32]

The Board has been subjected to substantial criticism from both the courts of appeals and various commentators concerning our previous decisions relating to the determination of appropriate units in the health care industry.[33] An analysis of the criticisms of the Board indicates that complaints concerning the Board's framework have focused on two units which the Board has found to be potentially appropriate and those who have criticized the Board would not allow. Thus the issue of substantial litigation and debate, which has frustrated effective and efficient application of the Act to the health care industry, has been the Board's allowance of a separate unit of registered nurses, apart from other professionals, and its allowance of a separate unit of skilled maintenance personnel, separate from a general service and maintenance unit. It has generally been conceded that the other units previously authorized by the Board would be appropriate under any proposed formulation.

The courts of appeals that have criticized the Board have adopted a completely new test for determining appropriate units in the health care industry—the so-called disparity-of-interest test.[34] For the reasons discussed above, we find this test not to be compelled by the legislative history of the health care amendments of the Act, and find that it would deprive the Board of the flexibility to determine appropriate units which Congress intended the Board to exercise in this area.

Further, we find the logic of the disparity-of-interest test to be at odds with the Board's historic role in determining appropriate units. Under that test, the Courts of Appeals for the Ninth and Tenth Circuits have suggested that the Board is under an obligation to seek out the largest possible appropriate unit, and to find it, and only it, to be the appropriate unit.[35] The logical extention of this principle is demonstrated by Chairman Van de Water's dissent here, and the Ninth Circuit's recent decision in *HMO International* v. *N.L.R.B.* Both the Chairman here, and the court in *HMO* would effectively limit health care facilities to two units for collective bargaining, one of professionals and one of nonprofessionals. Such a unit approach is entirely consistent with the disparity-of-interest analysis. But it is entirely inconsistent with the Board's historic approach to unit determinations. Had Congress intended to work such a radical departure in Board unit determinations, we hardly think it likely that it would have relegated its instructions to a few am-

[30] As long ago as 1908, the Supreme court stated that "the reenactment by Congress, without change, of a statute, which had previously received long continued executive construction, is an adoption by Congress of such construction." *United States* v. *Cerecedo Hermanos Compania*, 209 U.S. 337, 339 (1908); see also *Commissioner of Internal Revenue* v. *Flowers*, 326 U.S. 465, 469 (1946).

[31] *Morand Brothers Beverage Company, et al.*, 91 NLRB 409, 418 (1950), enfd. 190 F.2d 576 (7th Cir. 1951).

[32] The Chairman's two-unit approach, grouping all professional health care employees in one unit and all nonprofessional employees in another, constitutes an abdication of our statutory responsibility and sacrifices the employees' right to be represented within a unit which may more effectively reflect their particular interests. The suggestion that all employees whose sole shared trait is their professional or nonprofessional status can bargain effectively within a single unit sacrifices workplace reality for employer convenience.

[33] *Allegheny General Hospital* v. *N.L.R.B.*, 608 F.2d 965 (3d Cir. 1979); *Presbyterian/St. Luke's Medical Center* v. *N.L.R.B., supra; N.L.R.B.* v. *HMO International/California Medical Group Health Plan, supra.* See also Husband, *Determining Appropriate Bargaining Units in Health Care Institutions—The Gap Widens*, 32 Labor Law Journal 780 (1981).

[34] *Presbyterian/St. Luke's Medical Center* v. *N.L.R.B., supra; HMO International, et al.* v. *N.L.R.B., supra.*

[35] *Id.*

biguous statements in the legislative history. Rather, it would have proceeded along the lines originally suggested by Senator Taft, that the specific number of appropriate units be specified in the statute. This Congress did not do.

The formulation proposed by our dissenting colleagues is even more restrictive than those which were specifically rejected during the amendment process as too inflexible. The American Hospital Association[36] (AHA) and Senator Taft[37] each sought unsuccessfully to limit the number of health care bargaining units to four; both were considered overly stringent.[38] Under the majority's health care unit system there are only three more *potentially* appropriate units than the four proposed by the AHA and Senator Taft.[39]

The final misapprehension evidenced by the dissenters is their characterization of the disparity-of-interest test as an analytical system unrelated to the community-of-interest test. The community-of-interest test, by its very nature, consists of both an examination of the similarities among the employees in a requested unit and, implicitly, an evaluation of the characteristics which differentiate the proposed unit members from their fellow employees. The disparities which set apart one group of employees from another compose one of the factors which is necessarily considered within the overall unit appropriateness test. See, for example, *Shriners Hospitals for Crippled Children*,[40] where all members of a divided Board focused on "notable disparity of interests between employees in different job classifications," and found the requested unit inappropriate. While this "disparity of interests" language has not consistently been reiterated in subsequent Board decisions, the equivalent requirement that the appropriate unit have a "separate and distinct" or simply "distinct" community of interest has remained the linchpin. See *Shriners Hospitals, supra; Newton-Wellesley, supra,* and cases cited therein; *Addison-Gilbert Hospital*, 253 NLRB 1010 (1981); and *The Long Island College Hospital*, 256 NLRB 202 (1981). A careful reading of our unit determination cases reveals that we have applied the disparity-of-interest test as *one aspect* of our analysis. While it may not always be identified as such, it is an inherent element in the broader, traditional, and congressionally sanctioned approach to our unit determination function.

In reaching this position we believe we have struck the proper balance of carrying out our responsibilities under the statute, heeding the legislative warnings, and accommodating the special needs and concerns of a vital industry. We believe it is important to emphasize at this point that the principal purpose of the health care amendments was to introduce the orderly processes, protections, and restraints of the Act to the nonprofit health care sector. The special concern about the dangers of disruptions within this industry do not refute this premise. See Leg. Hist. at 375 (remarks of Senator Taft):

> . . . the only thing that prevents strikes is the establishment and maintenance of a good collective bargaining climate. I believe the best way to assure that kind of climate is by covering employees in the private health care field under the National Labor Relations Act in essentially the same manner that employees in other industries are covered.

To assure that our health care unit approach is clear and is not misunderstood, we will recapitulate the procedure we follow. We begin with a maximum of seven *potentially* appropriate units, derived through our 8 years' experience with the industry: physicians, registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees, and maintenance employees. These units are neither presumptively appropriate nor will they invariably be granted. They are, rather, commonly found employee groups which *may* warrant their own bargaining units if it is adequately demonstrated that they actually possess a distinct community of interest, separate and apart from other hospital employees. Accordingly, if a petitioner seeks to represent a unit comprised of one such potentially appropriate group, we then apply the various community-of-interest criteria to the particular employees involved to determine whether they in fact comprise an appropriate bargaining unit. If sufficient intragroup identity is established and there are sufficient distinctions separating these employees from others at the facility, we will find the pe-

[36] See Coverage of Nonprofit Hospitals Under National Labor Relations Act, 1973. Hearings on S. 794, S. 2292 before the Subcommittee on Labor of the Committee on Labor and Public Welfare, 93d Cong., 1st sess. at 147148.

[37] S. 2292. See Leg. Hist. at 457–458.

[38] The notion that in rejecting these proposals Congress may have preferred an even smaller maximum number of units is unsound. As our examination of the Legislative History above shows, the rejection was for exactly the opposite reasons. In addition, the Taft proposal, quoted earlier in this decision, did not foreclose the possibility of grouping together two or more of the classifications he outlined. All that would have been required is that, *if*, for example, a unit of technical employees were found appropriate, then *all* technical employees would have been included in that unit. It neither required that a technical unit be found appropriate nor precluded the inclusion of technical employees within another of the employee units.

[39] Our approach, in practice, actually exceeds the rejected four-unit limit by only two; the seventh potentially appropriate unit, one of medical staff doctors, appears almost nonexistent. In the 8 years since the amendments' enactment the Board has considered only two cases dealing with such a unit.

[40] 217 NLRB 806 (1975).

titioned-for unit appropriate. If they fail to demonstrate such singular identity, we will not find the unit appropriate. Should a petitioner seek to represent a unit of employees not among the seven potentially appropriate units named above, we will, absent a showing of *extraordinary* circumstances, dismiss the petition.[41] While this approach may occasionally produce a case such as *Michael Reese Hospital and Medical Center*,[42] where chauffeur-drivers were granted their own bargaining unit, we believe that such "additional unit" cases will be rare, and, in fact, greatly outnumbered by cases where separate representation for one of the seven potentially appropriate units will be found unwarranted. See *Mount Airy Psychiatric Center, supra*, where we denied a request for a separate RN unit because of an insufficient showing of disparity of interest from other professional employees; *Kaiser Foundation Health Plan of Colorado and Permanente Services of Colorado, Inc.*,[43] where we dismissed a petition for a unit of non-RN professionals because certain RNs should have been included; and *Appalachian Regional Hospitals, Inc.*,[44] where we included business office clericals in a unit with all service, maintenance, and technical employees.

This approach offers neither facile, predetermined answers nor unyielding rigidity. It does require a thorough, case-by-case analysis of the facts and circumstances presented. We believe it provides a structure for analyzing unit appropriateness which accommodates both the representational rights of health care employees and the congressional concern about the dangers of disruption of hospital operation inherent in unit multiplicity.

The potentiality of appropriateness and the careful scrutiny applied in reaching an ultimate determination are particularly notable in maintenance unit cases. Applying our test to these employees requires consideration of a number of factors which, while considered in nonmaintenance unit cases, do not rise to an equal level of significance. Among such factors are the job tasks involved and the level of skills required to perform them, the location of the maintenance department, the amount of work integration with other employees, and the level of personnel interchange with other employees. To illustrate how this analysis works, we need only refer to some Board decisions. For example, we have determined that in order to find appropriate a separate health care maintenance unit there should be only minimal work integration and insignificant job-related contact between the maintenance and service employees. See, e.g., *St. Vincent Hospital and Medical Center of Toledo, Ohio*, 241 NLRB 492 (1979); *Southern Maryland Hospital Center*, 241 NLRB 494 (1979). In the non-health care sector this factor is less important and separate maintenance units have been found appropriate despite substantial interaction with other employees.[45] In addition, we have generally relied on a higher level of skills as indicative of a disparity of interests between the maintenance and the service employees. See, e.g., *Faulkner Hospital*, 242 NLRB 47 (1979); *Southern Baptist Hospitals, Inc.*, 242 NLRB 1329 (1979). However, because of the broad range of functions usually performed by maintenance department employees, it has not been found necessary that every employee demonstrate advanced skills in order to include them within the unit.[46] We also look for a variance between the service employees' wages and the maintenance employees' wages, which reflects to us the employer's acknowledgment of the different job duties and responsibilities of these groups. See *Sutter Community Hospitals of Sacramento, Inc.*, 227 NLRB 181 (1976).

The nature of this inquiry and balancing of factors is such that there will inevitably be disagreements among the analysts as to whether a particular maintenance group may be said to possess an independent identity or whether its identity has been subsumed within a larger service and maintenance process. That Board Members may disagree as to whether a requested maintenance unit meets this standard of appropriateness does not, however, alter the fact that the Board is charged with the responsibility of deciding unit appropriateness. As we indicated earlier in this decision, judicial criticism of the Board's consistent position on maintenance units in the health care industry may be a function of our failure to describe the analytical procedure we follow in all health care cases. As should be clear from this decision, the Board has not adopted the unit approach used in non-health care industries, but rather has selected a more limited category of units within which to apply community-of-interest criteria. We regard all other units as inconsistent with the Legislative History, unless extraordinary and compelling circumstances are shown to

[41] Our obligation, under Sec. 9(b) of the Act, precludes us from dismissing the petition without considering evidence of special or unique circumstances that may justify finding appropriate a unit consisting of employees other than the possible six or seven named above. However, while there may thus be an occasional exception, we believe that such extraordinary cases will be few and, therefore, pose no threat of undue proliferation of bargaining units. Indeed, we will be exercising precisely this due consideration to avoid unit proliferation in determining whether the circumstances of such a case are so unusual and extraordinary as to justify a separate unit.

[42] 242 NLRB 322 (1979).

[43] 230 NLRB 438 (1977).

[44] 233 NLRB 542 (1977).

[45] See *Verona Dyestuff Division, Mobay Chemical Corporation*, 225 NLRB 1159 (1976); *Crown Simpson Pulp Company*, 163 NLRB 796 (1967).

[46] See *Divine Providence Hospital of Pittsburgh*, 248 NLRB 521 (1980).

exist. Some may view this approach as falling short of Congress' wish; others may view it as more rigorous than Congress required. We are convinced that it strikes the proper balance.

Turning to the particular circumstances of this case, the 39 employees in the 4 maintenance departments perform duties requiring skills and experience not required of the approximately 400 service employees. Some of these employees possess greater skills than others, in accord with the requisites of their individual job duties. Although not currently a prerequisite for employment, the hospital prefers to fill maintenance positions with persons who have achieved either a journeyman grade level or who have substantial relevant experience in their field. The most highly skilled among the maintenance employees are the boiler operators, two of whom are city-licensed steam operators whose job description requires 4 years' experience for applicants; the painter/vinyl hanger, who must have a minimum of 5 years' experience for the position; and the carpenters, cabinetmakers, and utility operators who each must possess 4 years' experience in their respective trades to qualify for the job. Two of three years' experience is required for the positions of painter, plumber, electrician, pneumatic tube operator, electronics technician, communications technician, and utility mechanic. Refrigeration mechanics, HVAC mechanics, and HVAC helper/trainaes must have at least a year's experience for employment with the hospital. Less experience is needed for the position of general maintenance mechanic and no prior experience is required for the X-ray processor mechanic, maintenance helpers, groundskeeper, or refuse and linen collectors.

In addition to the experience requirements, boiler operators usually require a full year of on-the-job training in order to perform adequately their duties which include operating, maintaining, and repairing steam-generating boilers and air-conditioning chillers, chemically testing and adjusting the feed water needed in these machines, and checking the status of the air-handling units by use of a computer system. Up-to-date knowledge of applicable codes and ordinances is mandatory.

The utility operators also need an additional year of on-the-job training, inasmuch as they work alongside the boiler operators in performing the same kinds of critical functions in properly regulating the environment within the hospital's physical plant.

The plumber's job requires completion of an orientation program which lasts from 2–4 weeks upon entry to employment. Installation and repair of every variety of plumbing fixture, piping systems, including biomedical piping, and regulating and terminal devices, such as oxygen, vacuum, nitrogen, etc., are the major responsibilities of the person in this position.

On-the-job training for the electrician generally lasts from 1 to 3 months. Weekly operation of the electrical standby power system, testing of all high-voltage equipment, inspecting all electrical components, and performing preventive maintenance on all such devices requires great familiarity with the entire system.

From 3 to 6 months is needed on the job to familiarize the pneumatic tube operators with the hospital's pneumatic system and to ensure that it is functioning properly. Unstopping jams in the system whenever they occur as well as troubleshooting through reading schematic diagrams and blueprints are among their primary responsibilities.

At least 6 months' on-the-job training is required for refrigeration mechanics to learn proper installation and repair techniques for all refrigerated devices, including those units used in blood and drug storage.

HVAC mechanics require only 2 to 4 weeks of on-the-job training, while the HVAC trainees need 6 months to 1 year of such additional training. A wide variety of skills is required, including experience with the electrical system which supplies the power for the heating and air-conditioning equipment, as well as a thorough understanding of the hospital's system.

The general maintenance mechanic requires from 2 to 4 weeks of job training in addition to the above-mentioned experience requirement in order to assure that general and routine mechanical maintenance assignments are completed expeditiously, with the least inconvenience to patients, visitors, and other employees.

In order to acquire proficiency in maintaining and cleaning the X-ray processing and development equipment, the mechanic requires between 1 and 3 months of actual job training. The maintenance helper needs from 2 to 4 weeks' training on the job, as does the groundskeeper, in order to become familiar with their responsibilities both inside and outside the hospital facility. Only 1 to 2 weeks of on-the-job training is needed for refuse and linen collectors to acquaint themselves with the automatic, key-operated chute system as well as the manual means of properly handling their sanitary maintenance functions.

In addition to such training the hospital offers courses specifically designed to enhance the maintenance employees' job performance as part of a continuing process of keeping them current with new techniques in an evolving medical facility.

There is no evidence that any employees in the maintenance categories perform service department work and the service employees perform no maintenance duties. There is complete separation of supervision and direction between these two groups as well.

Because of the nature of their work, the boiler-room employees are entirely segregated from all other hospital personnel. However, the majority of the functions performed by maintenance employees necessitates their working throughout the entire facility, wherever their expertise is needed at the time. Installing, repairing, and maintaining all the equipment required in the effective functioning of the hospital is dependent upon the presence of maintenance employees in all parts of the facility. Therefore, these employees are in frequent contact with every category of health care personnel, but they perform their duties independently. Such incidental contact is not indicative of functional integration.

The hospital's Pay Plan A covers both service and maintenance employees, but maintenance workers are concentrated at the high end of this scale, reflecting their greater skills and responsibilities. Eleven of the maintenance positions—20 of the 39 employees—are included in the highest pay grade. Two other maintenance positions, including three employees, are in the second highest pay grade.

The maintenance employees in this case closely resemble those in both *Faulkner Hospital, supra*, and *Southern Baptist Hospital, Inc., supra*. They report to separate locations at the beginning of their work shifts, are administered separately from the service department, are separately supervised, and possess overall greater skills and experience than are required for the service employees. They share no duties with the service departments. They are reponsible for a variety of maintenance-related functions without being functionally integrated with other hospital departments.

On balance, we believe the maintenance department here constitutes an appropriate unit, including employees classified under a gamut of job descriptions who nonetheless share sufficient work characteristics to unify their overall collective-bargaining interests. In so doing, we are accommodating both the Act's Section 9(b) direction to "ensure employees the fullest freedom in exercising the rights guaranteed by this Act" and the congressional committee report's cautionary instruction to prevent proliferation of bargaining units.

DIRECTION

It is hereby directed that the Regional Director for Region 26 open and count the impounded ballots, and take further appropriate action as may be required.

CHAIRMAN VAN DE WATER, dissenting:

The conclusion of my colleagues in the majority that a unit of maintenance employees in this hospital constitutes an appropriate unit for bargaining cannot withstand scrutiny because: it ignores and is inconsistent with a specific congressional mandate that the Board prevent the proliferation of bargaining units in health care institutions; it ignores and is inconsistent with the interpretation of that congressional mandate by the courts of appeals; lastly, the modified rationale used by the majority herein is inconsistent with the Board's former position the last time it addressed this issue. The time is long overdue for this Board to formulate a plain and coherent approach to resolving unit issues in the health care industry with basic reliance on congressional intent as interpreted by the courts.

I.

When Congress broadened our jurisdiction in 1974 to include nonprofit hospitals,[47] it added Section 2(14) to the Act, which placed these hospitals in a wider grouping of "health care institutions." Such an institution was defined in Section 2(14) as "any hospital, convalescent hospital, health maintenance organization, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick, infirm, or aged person [sic]." Recognizing, however, "that the needs of patients in health care institutions required special consideration in the Act,"[48] Congress enacted special provisions in Section 8(d) and (g). Section 8(d), as amended, requires earlier notice of contract termination or modification to the other party and to the Federal Mediation and Conciliation Service (FMCS) where collective-bargaining involves a health care institution; requires a labor organization to give 30 days' notice of a dispute to the FMCS, where bargaining is for an initial contract; and requires the parties to participate in mandatory mediation by FMCS. Section 8(g) requires that a labor organization give a health care institution and FMCS 10 days' notice prior to striking or picketing at the premises. However, as pointed out by former Member Penello in his dissenting opinion in *Allegheny General Hospital*,[49] Congress had a further

[47] Public Law 93-360, 88 Stat. 395.

[48] S. Rept. 93-766, 93d Cong., 2d sess. 5 (1974), "Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974" (hereinafter Leg. Hist.) at 10.

[49] 239 NLRB 872, 880 (1978), enforcement denied 608 F.2d 965 (1979).

concern which it did not choose to meet by formally amending the Act:

> The legislators desired . . . to limit the *incidence* of strikes and work stoppages by instructing the Board to minimize the number of bargaining units in this industry. Congress understood that the risk of disruptive work stoppages in a health care facility would be increased the larger the number of bargaining units, primarily because of the heightened possibility of jurisdictional disputes among competing unions and the traditional reluctance of many employees to cross picket lines erected even by unions other than their own.

To ensure that the Board would restrict the number of units in health care facilities, the following now-famous passage was placed in the House and Senate Committee Reports:[50]

> Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB [403] (1974), and *Woodland Park Hospital*, 205 NLRB [888] (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB [1232] (1973).[1]

[1] By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.

According to Senator Taft, one of the cosponsors of the 1974 amendments, this "report language was agreed upon to stress the necessity to the Board to reduce and limit the number of bargaining units in a health care institution," and he emphasized that he could not "stress enough, however, the importance of great caution being exercised by the Board in reviewing unit cases in this area. Unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages must be prevented."[51] Senator Taft also commented, in relation to the footnote qualification of the reference to *Extendicare of West Virginia, supra*, in the committee reports:[52]

> Part of the unit findings in that case, it can be argued, was overly broad and not consistent with minimization of the number of bargaining units in health care institutions. Certainly, every effort should be made to prevent a proliferation of bargaining units in the health care field and this was one of the central issues leading to agreement on this legislation. In this area there is a definite need for the Board to examine the public interest in determining appropriate bargaining units.

And Senator Williams, also a cosponsor of the legislation, stated, *inter alia*, "sometimes circumstances require that there be a number of bargaining units among nonsupervisory employees, particularly where there is such a history in the area or a notable disparity of interests between employees in different job classifications."[53]

II.

What this legislative history unambiguously reveals to me is that Congress did not intend for the Board to utilize its traditional community-of-interest test to determine bargaining units in health care facilities, but rather that it should minimize the number of units in such institutions to promote the policy of limiting the likelihood of work stoppages. Notwithstanding the evident intention of Congress, the Board, in *Allegheny General Hospital, supra*, granted a separate unit of maintenance employees. The Board surveyed the legislative history and case law to that date, and concluded, "We think it is also clear that Congress intended that we should rely on our traditional community-of-interest criteria in making unit determinations in the health care industry."[54] Quoting the remark, referred to above, by Senator Williams in the legislative history, the Board stated that the comment "shows that Congress intended that the appropriateness of health care units should be determined by the Board's traditional community-of-interest criteria."[55] The Board continued:

> Beginning with the analysis of the legislative history described above, a majority of the Board decided to apply traditional community-of-interest criteria to decide the unit issues raised by these initial cases [referring to the six initial lead unit cases in the health care area cited on pp. 875–876 of the decision]. *Application of these criteria led the Board majority to conclude that the Board's unit approach to the industrial sector would also suit the health care industry*; i.e., satisfy the policy objective of Section 9(b)—to guarantee employees the fullest freedom to exercise the rights granted by the Act—and avoid proliferation. [Emphasis supplied.] [*Id.* at 876.]

[50] Leg. Hist., *supra* at 12 and 274–275.
[51] *Id.* at 114.
[52] *Id.* at 255.
[53] *Id.* at 363.
[54] 239 NLRB at 873.
[55] *Id.* at 875.

The Board concluded that both units limited to maintenance employees and powerhouse employees in health care institutions were appropriate based on industrial standards, stating at 878:

> Under *American Cyanamid Company* [131 NLRB 909 (1961)], and the pre-1974 test for powerhouse units, the issue is essentially whether the employees sought are in [sic] identifiable group with a community of interest that is sufficiently separate or distinct from the other unrepresented service and maintenance employees to warrant separate representation. For this reason, we find both tests are consistent with the approach we have taken to unit issues in the health care industry.

The Board, referring to a comment of Senator Taft in the legislative history,[56] decided that Congress merely did not want the Board to create,[57]

> . . . a unit pattern similar to that of the construction industry, where employees have been grouped into units according to craft skills and job functions. If the pattern of the construction industry were used as a model for the health care industry, health care employees would be grouped into units according to "*each* professional interest and job classification."[58]

In today's decision, the majority accurately observes at the outset:

> We announced [in *Allegheny*] that community-of-interest standards, as set forth in *American Cyanamid Company*, would be applied to health care maintenance employee unit determinations. *American Cyanamid* did not involve a health care employer, but rather dealt with the factors tending to establish that the maintenance employees therein had demonstrated a distinct community of interest sufficient to warrant their own bargaining unit, separate from the production employees; i.e., level of skills; amount of work integration with production employees; degree of interchange between production and maintenance departments; degree of shared supervision; and location of the maintenance department. Applying these factors to the factual setting in *Allegheny General*, the Board found that the maintenance employees at that hospital should be granted their own unit. [*supra*, 1025–1026.]

This statement is clear, as were the statements quoted previously from the *Allegheny* decision itself, that the Board determines health care units on the same community-of-interest basis it does in other industries. Nonetheless, noting that the United States Court of Appeals for the Third Circuit had denied enforcement to the Board's order in *Allegheny*, the majority suggests that its decision was "imprecise" and "susceptible to misinterpretation," thus resulting in unfavorable appellate review. (*Supra* at 1026) Then, after discussing the legislative history and many of the same Board unit determinations that were analyzed in *Allegheny*, my colleagues declare that, "The most explicit evidence that the Board does not adhere to traditional unit criteria in health care unit determinations is our decision in *Duke University*," [217 NLRB 799 (1975)] (at 1028), in which the Board refused to grant separate representation to switchboard operations at a hospital. Finally, the majority flatly states that, "As should be clear from this decision, the Board has not adopted the unit approach used in non-health care industries." (*Supra* at 1032–33.)

A disinterested observer is compelled to note that, although the Board is reaching the same result which it did in *Allegheny*, and although it reviews most of the same previous Board decisions determining hospital units that it did in that case, the present rationale contradicts that set forth in *Allegheny*. In brief, the Board in *Allegheny* decided that Congress intended for the Board to apply its traditional, industrial sector, community-of-interest test to health care facilities, and that the mandate against proliferation meant only that Congress did not desire to see unit fragmentation along the lines of construction industry. And the Board said in *Allegheny* that it had been following exactly this course since the passage of the health care amendments and would continue to do so. Today, however, the Board declares that it has not, does not, and will not apply traditional principles of unit determination to the health care industry. Rather, it asserts that the Board has,

> . . . identified certain groups of employees commonly found in a health care institution: physicians, registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees, and skilled maintenance employees. Often these groups of employees constitute the entire employee complement, and,

[56] Senator Taft said, "The administrative problems from a practical operational viewpoint and labor relation [sic] viewpoint must be considered by the Board on this issue [of unit proliferation]. Health-care institutions must not be permitted to go the route of other industries, particularly the construction trades, in this regard." Leg. Hist., *supra* at 114.

[57] 239 NLRB at 875.

[58] Former Member Penello answered this argument succinctly in his dissent in *Allegheny*, stating, *inter alia* at 883: "[A]ny impartial reading of the sentence quoted discloses that it refers generally to the necessity of not duplicating the unit mold of other industries in the health care field, and cites the construction trades only as a particularly undesirable example of unit proliferation."

> almost invariably, all employees will fall into one of these enumerated categories. Based on our experience in examining the employee complement at health care facilities, we have determined that these seven named classifications represent the groupings of employees that *may* constitute appropriate units for bargaining. Only after determining that the unit sought fits one of these classifications do we then apply our traditional unit principles to determine whether the specific employees involved do, in fact, display the requisite community of interest to warrant separate representation. [*Supra* at 1029.]

The basic difficulty with this is that in *Allegheny* and other decisions the Board has explicitly stated that the community-of-interest test was the means by which the several groups which normally comprise the entire employee complement at any health care institution were found to be appropriate; e.g., the application of the *American Cyanamid* test for determining the appropriateness of maintenance units in the health care as well as the non-health care field. Furthermore, it is plain that the basic units which the Board says it finds appropriate in the health care field are the same ones which, to the extent there is an analogy, it finds appropriate in the industrial sector: business office clericals, technical employees, maintenance employees, and service (production) and maintenance employees. In addition, as the majority acknowledges later in its opinion (sl. op., p. 25), the Board since *Allegheny* has also found appropriate a unit of chauffeur-drivers in a hospital.[59]

III.

Based upon this newly developed rationale, my colleagues in the majority analyze a number of Board health care unit decisions to demonstrate that traditional principles have not been followed and that the Board has avoided proliferation of bargaining units as contemplated by Congress. The cases cited by the majority support neither point, and will be treated briefly.

The majority first notes that in *St. Catherine's Hospital*,[60] it declined to grant a separate unit of LPNs apart from all other technical employees, on the basis that the footnote reference in the congressional admonition's citation of *Extendicare of West Virginia, Inc.*,[61] disclosed a legislative intent that the Board not approve units limited to LPNs. What my colleagues overlook is that the Board has decided in the industrial sector that "a unit of technical employees is inappropriate where it does not include all in that category."[62] What they also overlook is that, in otherwise citing *Extendicare* with approval in the legislative history, Congress plainly placed its imprimatur upon the denial of units limited to technical employees. Nevertheless, the Board has granted such units in opposition to congressional intent.[63] Accordingly, the Board can claim little credit for failing to subdivide a technical unit by job classification when Congress did not approve of granting separate technical units.

Next, my collagues observe that, in *Kaiser Foundation Hospitals*,[64] the Board refused to permit a separate unit of pharmacists apart from other unrepresented professionals (the registered nurses were already represented). However, they fail to add that the Board in *Kaiser* refused to give the unit based upon application of traditional industrial unit criteria:[65]

> . . . as we stated in *Mercy Hospitals of Sacramento, Inc.*, 217 NLRB [765] (1975), "Thus, although there is a diversity of skills between each of these professional groups, their skills, interests, and working conditions are, in many respects, no more diverse than those of employees in a production and maintenance unit in the industrial sphere or in the overall service and maintenance unit in the health care industry. . . ." Although the pharmacists obviously share a greater community of interest with each other than they do with the other professional employees, we do not consider that they possess interests evidencing community of interest with each other separate from that shared with the other employees in the health care industry.

The Board further points to its decisions in *Jersey Shore Medical Center-Fitkin Hospital*,[66] where it refused to allow a separate unit of nursing school instructors apart from other which it denied separate

[59] *Michael Reese Hospital and Medical Center*, 242 NLRB 322 (1979).

[60] *St. Catherine's Hospital of Dominican Sisters of Kenosha, Wisconsin, Inc.*, 217 NLRB 787 (1975).

[61] *Extendicare of West Virginia, Inc., d/b/a St. Luke's Hospital*, 203 NLRB 1232 (1973). As stated in section I of this opinion, Senator Taft commented that the footnote, "By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision," was inserted because, "Part of the unit findings in that case, it can be argued, was overly broad and not consistent with minimization of the number of units in health care institutions." In *Extendicare*, the Board permitted a unit of LPNs separate from a unit of service, maintenance, and other, non-LPN technical employees, and also, contrary to the position of the employer, excluded business office clerical employees from the service, maintenance, and technical unit.

[62] *General Electric Company*, 173 NLRB 399, 400 (1968).

[63] The leading cases are *Nathan and Miriam Barnert Memorial Hospital Association d/b/a Barnert Memorial Hospital Center*, 217 NLRB 775 (1975), and *Newington Children's Hospital*, 217 NLRB 793 (1975).

[64] 219 NLRB 325 (1975).

[65] *Id.* at 326.

[66] 225 NLRB 1191 (1976).

representation to "Code 101," or registered nurses, and *New York Univeristy Medical Center*,[67] in nontenure track psychiatrists, apart from "Code 102," or tenure (or tenured) track psychiatrists, and other physicians. It is evident in both cases that, although the Board referred to the congressional mandate against hospital unit proliferation, it relied on numerous conventional factors which clearly showed that neither petitioned-for group had a separate community of interest under traditional principles.[68] In short, the Board seeks to prove that it has limited the proliferation of hospital units by refusing to give a certain classification of registered nurses their own unit, or to grant a category of psychiatrists a unit separate even from other psychiatrists, though it is plain that neither unit would have been appropriate under any circumstances—with or without an expression of special congressional concern.

The majority also refers to *Levine Hospital of Hayward, Inc.*,[69] wherein the Board refused to give 7 medical clerks and transcribers a separate unit apart from some 150 nonprofessional employees, who were already represented in units of service and maintenance employees, business office clerical employees, and X-ray technicians. After an extensive recitation of relevant facts, the Board concluded that these employees shared "a very close community of interest with the employees in the currently existing service and maintenance unit," and should be included in that unit if they desired representation.[70] Plainly, the Board was confronted by a very unusual set of circumstances in *Levine*, a petition for a tiny number of unrepresented, nonprofessional employees, where the other nonprofessional employees were already divided into three units, and where the petitioned-for employees shared a "very close" community of interest with employees in the service and maintenance unit. The denial of residual status to such a unit under these exceptional conditions can scarcely be deemed a major contribution toward containing unit proliferation in the health care industry.

As alluded to previously, the Board is of the opinion that its refusal of a separate unit to switchboard operators in *Duke University, supra*, marks its most explicit deviation from traditional unit criteria in health care facilities. Chairman Murphy and Members Fanning and Jenkins denied the unit, finding that, although the switchboard operators possessed a distinct community of interest, the mandate against nonproliferation precluded them from granting the unit. Members Kennedy and Penello found that such a unit did not possess a separate community of interest either in the health care or in any other industry.[71] My review of the facts persuades me that Members Kennedy and Penello properly found that, under our usual community-of-interest criteria, the unit was inappropriate. Furthermore, I know of no instance in the industrial sector in which such a unit has been found appropriate, nor do I know of another instance in which such a unit has been requested in a health care facility. Thus, failing to grant switchboard operators their own units is insignificant as an example of Board concern over fragmentation of units in health care institutions.

Later in their opinion, the majority notes that a unit limited to registered nurses was denied in *Mount Airy Psychiatric Center*,[72] but fails to consider that the Board did so on the basis that the nurses therein did not share a community of interest separate from that of other employees. Finally, in *Appalachian Regional Hospitals*,[73] cited by the majority, the Board included business office clericals in an overall unit of nonprofessional employees because that was the unit requested by Petitioner:

> [T]he business office clericals share a community of interest with the other employees sufficient to warrant their inclusion in the unit. It has long since been settled that the unit sought need only be *an* appropriate unit, not the most appropriate unit.

In sum, the cases relied on by the majority to establish that the Board has followed the congressional mandate against unit proliferation in health care institutions fall into three categories: those cases in which, although arising in a health care setting, unit determinations were clearly made on the same basis they would have been in any other industry *(St. Catherine's Hospital, Kaiser Foundation Hospitals, Mount Airy Psychiatric Center*, and *Appalachian Regional Hospitals)*; those cases in which, although explicitly relying on the congressional mandate in company with numerous traditional factors to deny a unit, the Board would clearly have found the units involved inappropriate entirely upon the community-of-interest factors alone *(Jersey Shore Medical Center* and *New York University Medical Center)*; and those cases in which the unit denied was so insignificant, and the precedent thus set so limited, as to amount to a trivial inhibi-

[67] *New York University Medical Center, a Division of New York University*, 217 NLRB 523 (1975).
[68] 225 NLRB at 1193; 217 NLRB at 526.
[69] 219 NLRB 327 (1975).
[70] *Id.* at 328.
[71] 217 NLRB at 800, fn. 8.
[72] *Mount Airy Foundation d/b/a Mount Airy Psychiatric Center*, 253 NLRB 1003 (1981).
[73] *Appalachian Regional Hospitals, Inc., Operator of June Buchanan Primary Care Center*, 233 NLRB 542, 544 (1977).

tion on unit fragmentation *(Levine Hospital of Hayward* and *Duke University).*

IV.

The courts of appeals have been clear and consistent in holding that the Board must give effect to the congressional admonition against unit proliferation and not apply traditional standards to decide unit issues in health care institutions. Time and again, the courts have denied enforcement to Board bargaining orders that did not comply with congressional intent. A brief, circuit-by-circuit, review of the important courts of appeals cases follows.

The Second Circuit, in *N.L.R.B.* v. *Mercy Hospital Association,*[74] refused to uphold a Board finding that a unit limited to hospital maintenance employees was appropriate, stating:

> Our reading of the legislative history leads us to conclude that in the 1974 amendment Congress was expressing concern not only that health care institutions be spared the egregious unit proliferation of the construction trades but that less extreme unit fragmentation arising from application of usual industrial unit criteria could also impede effective delivery of health care services. . . . Thus, we hold along with our sister circuits that when the Board makes a unit determination for health care institution employees, traditional community of interest factors "must be put in balance against the public interest in preventing fragmentation in the health care field."

The court thus clearly rejected the "construction trades" rationale advanced by the Board in *Allegheny* (see sec. II of this opinion).

The Third Circuit has denied enforcement of a Board bargaining order based on a unit limited to boilerroom operators, *St. Vincent's Hospital* v. *N.L.R.B.,*[75] and twice denied enforcement in cases involving orders based on units limited to maintenance employees, *Memorial Hospital of Roxborough* v. *N.L.R.B.*[76] *and Allegheny General Hospital* v. *N.L.R.B.*[77] In *St. Vincent's*, the court said:[78]

> The legislative history of the health care amendments . . . makes it quite clear that Congress directed the Board to apply a standard in this field that was not traditional. Proliferation of units in industrial settings has not been the subject of congressional attention but fragmentation in the health care field has aroused legislative apprehension. The Board therefore should recognize that the contours of a bargaining unit in other industries do not follow the blueprint Congress desired in a hospital.

In *Allegheny*, the court noted that the traditional *American Cyanamid* standard for determining the appropriateness of industrial maintenance units, embraced by the Board for application to health care facilities in its decision in the case, was improper; "*American Cyanamid* does not, in any way, consider the effects of bargaining unit fragmentation or the special public interest in hospital unit determination."[79]

The Seventh Circuit has declined to approve units limited to maintenance employees, *N.L.R.B.* v. *West Suburban Hospital,*[80] wherein the court said that the Board made "mere lip-service mention" of the congressional mandate, and to boilerroom operators, *N.L.R.B.* v. *Mary Thompson Hospital,*[81] stating, "Contrary to the position asserted by the Board, the proper focus in unit determinations in a hospital setting is *not* solely a traditional community of interest analysis."

The Ninth Circuit overruled the Board's decision to permit registered nurses a separate unit in *N.L.R.B.* v. *St. Francis Hospital of Lynwood,*[82] noting, *inter alia,* that, "From the legislative history of the 1974 Amendments to the Act, it is apparent that Congress sought to encourage the Board to find broader bargaining units in the health care industry rather than narrower ones." Referring to Senator Williams' remarks in the legislative history, quoted *supra*, the court concluded that:[83]

> . . . his statement was that "a notable *disparity of interests* between employees in different job classifications [emphasis added by court]" could sometimes require a number of bargaining units. We view that language and the remaining legislative history of the 1974 Amendments to the Act as requiring the Board to determine not the similarities among employees in the same job classification (indeed the fact that they share the same classification would inevitably lead to the discovery of many similarities), but instead the "disparity of interests" among employee classifications which would prevent a combination of groups of employees into a single broader unit thereby minimizing

[74] 606 F.2d 22, 27 (1979), cert. denied 445 U.S. 971 (1980).
[75] 567 F.2d 588 (1977).
[76] 545 F.2d 351 (1976).
[77] 608 F.2d 956 (1979).
[78] 567 F.2d at 592.
[79] 608 F.2d at 971.
[80] 570 F.2d 213, 216 (1978).
[81] 621 F.2d 858, 862 (1980).
[82] 601 F.2d 404, 414 (1979).
[83] *Id.* at 419.

> unit proliferation. The congressional approval of the trend toward broader units in the health care industry indicates an awareness that the traditional factor of community of interests would be subordinated to the directive against undue proliferation. However, by including non-profit hospitals within the Act, Congress sought to extend to hospital employees effective labor rights. By focusing upon the disparity of interests between employee groups which would prohibit or inhibit fair representation of employee interests, a balance can be made between the congressional directive and the employees' right to representation.

The court then remanded the case to the Board to decide the unit issue in light of this standard.[84]

The Tenth Circuit has, on three occasions, declined to approve units limited to registered nurses. In *Presbyterian/St. Luke's Medical Center*,[85] the court said:

> The legislative history here reveals a strong current of congressional concern for the problems engendered by unwarranted unit fragmentation whether it be in composition or scope. As we view it, the Board's refusal to consider Congress' directive with regard to scope issues has subjected the health care industry to the very dangers Congress sought to prevent.

The court specifically adopted the "disparity of interests" standard erected by the Ninth Circuit for unit determination in the health care industry. The other cases in which the court did not uphold registered nurses units are *Beth Israel Hospital and Geriatric Center* v. *N.L.R.B.*[86] and *St. Anthony Hospital Systems* v. *N.L.R.B.*[87] These two decisions were recently reaffirmed in pertinent part after *en banc* consideration by the Tenth Circuit, 688 F.2d 697 (1982).

V.

Having carefully reviewed the legislative history and the court decisions interpreting it, I arrive at the conclusion that, in a health care institution, separate units composed of all professional employees and all nonprofessional employees are appropriate for purposes of collective bargaining.[88] I have further reached the conclusion, along with the Ninth and Tenth Circuits, that a more limited unit of either professional or nonprofessional employees may be appropriate, but only where it is clearly established that the employees in the proposed unit have a notable disparity of interests from employees in the larger unit which would prohibit or inhibit fair representation for them if they were denied separate representation.[89]

I turn now to an evaluation of the facts in this case in light of that standard. The maintenance employees whom Petitioner would represent are drawn from 4 of the Employer's 90 departments. They constitute 39 employees out of a total hospital complement of some 1,300 employees and a service and maintenance complement of 438 employees. The requested unit is made up of six general maintenance mechanics, one electronics technician, two carpenters, two painters, one plumber, three electricians, six boiler operators, one painter/vinyl hanger, one X-ray processor mechanic, two cabinetmakers, one pneumatic tube mechanic, one utility operator, one refrigerator mechanic, two communication technicians, one HVAC (heating, ventilating, and air-conditioning) mechanic, one HVAC trainee/helper, one utility mechanic, two maintenance helpers, one groundskeeper, and three refuse and linen collectors.

It must be recognized initially that the Employer contracts out a substantial amount of its maintenance work, including major electrical and plumbing assignments. Charles Upchurch, the Employer's chief engineer, testified that half of the maintenance budget, $200,000 to $250,000 per year, is devoted to hiring independent contractors. According to Upchurch, there are two reasons for this:

> One reason is that most construction and remodeling requires permits, and these contractors have the qualifications and get permits to do construction. The other is that our men, primarily, have come up through the ranks and have never been through the apprenticeship program or a journeyman program to

[84] Accord: *N.L.R.B.* v. *HMO International/California Medical Group Health Plan*, 678 F.2d 806 (9th Cir. 1982).

[85] 653 F.2d 450, 455 (1981).

[86] 677 F.2d 1343 (1981).

[87] 655 F.2d 1028 (1981).

[88] Sec. 9(b)(1) of the statute specifically gives professional employees the right to be represented separately from nonprofessional employees.

[89] The assertion by the majority that application of the disparity-of-interest test results in a determination of only the "most appropriate" unit is plainly incorrect, inasmuch as a petitioner may establish the appropriateness of a smaller unit where the test is met.

Also, the majority's suggestion that Senator Taft's bill, S. 2292, which would have specified four appropriate units in health care institutions, was not enacted because it was "overly stringent" is wrong. The point was capably answered by the Ninth Circuit in *N.L.R.B.* v. *HMO International/California Medical Group Health Plan, supra*, 678 F.2d at 808:

> Senator Taft proposed an archetypical limitation of four units per facility, the units to be divided along the lines of professional, technical, clerical, and service and maintenance. These divisions were not enacted, and it is not clear whether they were thought to be too broad, too narrow, or merely too rigid.

> give them the experience necessary to do some of the technical work.

In fact, the hospital does not currently employ any maintenance worker who has achieved journeyman status. This leaves the hospital's employees, according to Upchurch, "to take care of the basic non-technical skills of repairing and maintenance to all equipment and structures within and outside the hospital." It is fair to conclude, therefore, that the petitioned-for employees possess no significant level of skill which would militate toward separate representation.

The evidence is that maintenance employees spend between 80 and 95 percent of their time working throughout the hospital itself. In so doing, maintenance employees have substantial and continuing contact with other employees, particularly service employees. They work with service employees in many of the same areas, often on the same equipment and facilities, and in close proximity and cooperation with them. Indeed, the majority acknowledges this (at 1034):

> . . . the majority of the functions performed by maintenance employees necessitates their working throughout the entire facility, wherever their expertise is needed at the time. Installing, repairing, and maintaining all the equipment required in the effective functioning of the hospital is dependent upon the presence of maintenance employees in all parts of the facility. Therefore, *these employees are in frequent contact with every category of health care personnel*, but they perform their duties independently. [Emphasis supplied.]

Looking at other relevant facts, the Regional Director himself found that, "The hospital maintains a single pay plan for hourly-rated service and maintenance employees known as Pay Plan A." He also found that, "All service and maintenance employees are eligible to receive the same fringe benefits. Furthermore, there is centralized control of labor relations policies, centralized maintenance of personnel records and a uniform system of discipline and discharge." In finding the requested unit appropriate, the majority notes that there is "complete separation of supervision and direction between service and maintenance employees," but fails to acknowledge there is separate supervision among maintenance employees as well, because they are divided into four different departments each having independent supervision. Service employees are similarly divided among themselves into separately supervised departments.

To summarize, these facts demonstrate that not only do the maintenance employees in this case not have a notable disparity of interests from other nonprofessional employees, but they do not share a community of interest sufficient to justify separate representation on a traditional basis: (1) there is substantial contracting out of maintenance work because in-house employees do not have necessary qualifications and skills; (2) no current maintenance employees have achieved journeyman-skill status; (3) maintenance employees are assigned to perform tasks requiring only "basic non-technical skills"; (4) maintenance employees spend the vast majority of their time working throughout the hospital, in substantial and cooperative contact with service employees; (5) service and maintenance employees are subject to the same pay plan; (6) service and maintenance employees are eligible to receive the same fringe benefits; (7) there is centralized control of labor relations policies and centralized maintenance of personnel records; (8) there is a uniform system of discipline and discharge; and (9) there is separate supervision among maintenance employees in different maintenance departments just as there is for service employees.

VI.

The foregoing review conclusively demonstrates what the Board itself conceded in *Allegheny General Hospital* and other cases that it uses the traditional community-of-interest standard to determine appropriate units in the health care industry and that the resulting unit pattern follows that in the industrial sector. Second, it is crystal clear that the legislative history of the 1974 amendments to the Act indicates that Congress intended for the Board to make a serious effort to minimize the number of bargaining units in the health care industry to reduce the likelihood of jurisdictional disputes and work stoppages interfering with patient care, and that it clearly did not want the Board to duplicate the industrial unit scheme. Further, where the Board has denied requested units in hospitals, it has explicitly done so on the basis of traditional principles; or, although referring to the congressional admonition against unit proliferation, it has reached the same result it would have under traditional principles; or, where it is arguable that a different result was reached based on recognition of the legislative history, it has been on the basis that congressional intent is adequately fulfilled by strictly refusing to allow units of telephone switchboard operators and residual units of medical clerks and transcribers. Finally, it has been shown that the facts here do not warrant a separate unit for maintenance employees under application of a community-of-interest standard, much less the disparity-of-interest standard, which I here adopt.

No matter how many artful semantic rerationalizations of its health care unit determination policy that the Board may invent, it will not persuade the courts of appeals to join it in ignoring the express will of Congress: the repeated refusal of the courts to uphold Board unit determinations made on a business-as-usual basis is sure testimony to that. I, therefore, respectfully suggest that it is time for my colleagues in the majority to show their flexibility and pragmatism and acquiesce in the process of bringing Board law in this area into line with congressional intent as interpreted by numerous courts of appeals.

MEMBER HUNTER, dissenting:

I must dissent from the majority's holding that the traditional community-of-interest test is the proper standard for unit determination in the health care industry and from the conclusion that the record in the instant case warrants finding appropriate a unit limited to the Employer-hospital's maintenance employees. In using the oft-rejected community-of-interest test to find a maintenance unit appropriate here, the majority has once again paid "mere lip-service mention"[90] to Congress' explicit directive that the Board give due consideration to preventing undue proliferation of bargaining units in the health care industry. Although the courts have repeatedly criticized the Board's unit determination in this industry,[91] the majority's analysis of the facts of this case continues to demonstrate an inability or unwillingness to recognize the simple fact that what would be "an appropriate unit" in another industry is not "an appropriate" unit in the health care industry. As set forth more fully, *infra,* Congress' direction that the Board limit the number of bargaining units in the health care industry mandates that the Board apply a stricter standard in determining appropriate units in this industry. In my view, the disparity-of-interest analysis, as set forth *infra*, embodies such a standard. Furthermore, application of that standard to the facts of this case demonstrates that the maintenance employees do not have such a disparity of interest from the Employer's other employees as to warrant representation in a separate unit.

Much has been written about the 1974 health care amendments to the National Labor Relations Act.[92] Accordingly, I will touch only briefly on the Board's preamendment treatment of this industry and on the legislative history of the amendment itself. Although the Wagner Act did not treat the health care industry differently from other industries, the Board did not assert jurisdiction over nonprofit hospitals until 1942.[93] Congress' unfavorable reaction to the assertion of jurisdiction was reflected in the Taft-Hartley amendments in 1947 which specifically excluded nonprofit hospitals from the jurisdiction of the Act.[94]

The exclusion of nonprofit hospitals was the subject of some criticism in the years following passage of Taft-Hartley. In the face of that criticism and of increasing labor unrest in the health care industry, Congress reconsidered the issue. In 1974, the health care amendments were enacted and the exemption of nonprofit hospitals was removed because there "was no acceptable reason"[95] to exclude employees of such hospitals from the coverage of the Act. The Act, however, was not amended by merely removing the exclusion of nonprofit hospitals from the definition of "employer" in Section 2(2). Instead, Congress recognized that the entire health care industry was unique and should be governed by certain restrictions not applicable to other industries.[96] Thus, the health care amendments curtailed the right to engage in strikes and picketing and contained special provisions regarding contract termination and mediation requirements.[97]

In addition, Congress recognized that the paramount public interest in maintaining uninterrupted accessibility to health care required further protection. Thus, if the National Labor Relations Act were to apply to the health care industry, special care would have to be taken to avoid the "ultimate disruptions in health care institutions caused by organization drives and related activities such as

[90] *N.L.R.B.* v. *West Suburban Hospital,* 570 F.2d 213, 216 (7th Cir. 1978).

[91] *N.L.R.B.* v. *HMO International/California Medical Group Health Plan,* 678 F.2d 806 (9th Cir. 1982); *Beth Israel Hospital and Geriatric Center* v. *N.L.R.B.,* 688 F.2d 697 (10th Cir. 1982), reaffirming *en banc Beth Israel Hospital and Geriatric Center* v. *N.L.R.B.,* 677 F.2d 1343 (10th Cir. 1981), and *St. Anthony's Hospital Systems* v. *N.L.R.B.,* 655 F.2d 1028 (10th Cir. 1981); *N.L.R.B.* v. *Fredrick Memorial Hospital, Inc.,* 111 LRRM 2680 (4th Cir. 1982); *Presbyterian/St. Luke's Medical Center* v. *N.L.R.B.,* 653 F.2d 450 (10th Cir. 1981); *N.L.R.B.* v. *Foundation for Comprehensive Health Services,* 654 F.2d 731 (9th Cir. 1981); *Mary Thompson Hospital, Inc.* v. *N.L.R.B.,* 621 F.2d 858 (7th Cir. 1980); *Allegheny General Hospital* v. *N.L.R.B.,* 608 F.2d 965 (2d Cir. 1979); *N.L.R.B.* v. *Mercy Hospital Association,* 606 F.2d 22 (2d Cir. 1979), cert. denied 445 U.S. 971 (1980); *N.L.R.B.* v. *St. Francis Hospital of Lynwood,* 601 F.2d 404 (9th Cir. 1979); *N.L.R.B.* v. *West Suburban Hospital,* 570 F.2d 213 (7th Cir. 1978); *St. Vincent's Hospital* v. *N.L.R.B.,* 567 F.2d 588 (3d Cir. 1977).

[92] See, generally, Vernon, *Labor Relations in the Health Care Field Under the 1974 Amendments to the National Labor Relations Act: An Overview and Analysis,* 70 NW.L Rev., 202 (1975).

[93] *Central Dispensary and Emergency Hospital,* 50 NLRB 393 (1943), enfd. 145 F.2d 852 (D.C. Clr. 1944), cert. denied 324 U.S. 847 (1945).

[94] Labor-Management Relations Act, Sec. 101, amending National Labor Relations Act, Sec. 2(2) (1947).

[95] S. Rept. 93-766, 93d Cong., 2d sess. 3 (1974), "Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act" (hereafter Leg. Hist.) at 10.

[96] Leg. Hist., *supra* at 143, Statement by Senator Dominick.

[97] Act of July 26, 1974, Public Law 93-360, 88 Stat. 395, amending National Labor Relations Act, 29 U.S.C. §§ 151-168 (1971). See in particular, Sec. 8(d) and (g) of the National Labor Relations Act, as amended.

strikes and slow downs."[98] Congress concluded that the object of minimizing work stoppages resulting from initial organizational activities, jurisdictional disputes, and sympathy strikes could best be achieved, and thus the likelihood of disruptions to health care would be reduced, by ensuring that *only* the minimal number of units would be found appropriate in the health care industry. Accordingly, the House and Senate Committee Reports contained the following directive to the Board:

> EFFECT ON EXISTING LAW
>
> BARGAINING UNITS
>
> Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB [403] (1974), and *Woodland Park Hospital*, 205 NLRB [888] (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB [1232] (1973).[1]
>
> [1] By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.[99]

Previous Board and court decisions have set forth at length various statements by Congressmen and Senators regarding this directive. Virtually every Senate and House legislator speaking in regard to the passage of the amendments admonished the Board to avoid a proliferation of bargaining units and directed the Board to make every reasoned attempt to accommodate broader units in the health care industry.

In particular, Senator Taft, a principal cosponsor of the nonprofit hospital bill, in an attempt to clarify any misunderstanding as to Congress' intent, stated:

> Certainly, every effort should be made to prevent a proliferation of bargaining units in the health care field and this was one of the central issues leading to agreement on this legislation. In this area there is a definite need for the Board to examine the public interest in determining appropriate bargaining units. *N.L.R.B.* v. *Delaware-New Jersey Ferry Co.*, 128 F.2d 130 (3rd Cir. 1942).[100]

Similarly, immediately prior to the final vote approving the amendments, Senator Williams, another cosponsor, also attempted to clarify Congress' admonition to the Board:

> While the Board has, as a rule, tended to avoid an unnecessary proliferation of collective bargaining units, sometimes circumstances require that there be a number of bargaining units among nonsupervisory employees, particularly where there is such a history in the area or a notable disparity of interest between employees in different job classifications.
>
> While the Committee clearly intends that the Board give due consideration to its admonition to avoid an undue proliferation of units in the health care industry, it did not within this framework intend to preclude the Board acting in the public interest from exercising its specialized experience and expert knowledge in determining appropriate bargaining units. (*N.L.R.B.* v. *Delaware-New Jersey Ferry Co.*, 128 F.2d 130 (3d Cir. 1942)).[101]

As indicated by the legislative history and by every circuit court that has considered this issue,[102] Congress clearly intended that, in determining appropriate units in the health care area, the Board should apply a stricter standard than its traditional community-of-interest analysis. As pointed out by the Third Circuit in *St. Vincent's Hospital* v. *N.L.R.B.*, 567 F.2d 588, 592 (1977):

> The legislative history of the health care amendments . . . makes it quite clear that Congress directed the Board to apply a standard in this field that was not traditional. Proliferation of units in industrial settings has not been the subject of congressional attention but fragmentation in the health care field has aroused legislative apprehension. The Board therefore should recognize that the contours of a bargaining unit in other industries do not follow the buleprint Congress desired in a hospital.

Nevertheless, a majority of the Board has continued to ignore court criticism and has persisted in usurping "major policy decisions properly made by Congress. . . ."[103] by failing to keep the number of bargaining units in the health care industry to a minimum.

Thus, in *Allegheny General Hospital*, 239 NLRB 872 (1978), where the Board found that a unit of maintenance workers very similar to the unit sought in this case constituted an appropriate unit, the Board stated that: "Congress intended that the appropriateness of health care units should be de-

[98] Leg. Hist., *supra* at 142, Statement by Senator Dominick.
[99] Leg. Hist., *supra* at 12.
[100] Leg. Hist., *supra* at 255.
[101] Leg. Hist., *supra* at 363.
[102] See fn. 91, *supra*.
[103] *Allegheny General Hospital* v. *N.L.R.B.*, 608 F.2d at 968, citing *American Ship Building Co.* v. *N.L.R.B.*, 380 U.S. 300, 318 (1965).

termined by the Board's traditional community of interests criteria . . . ."[104] In response to application of the community-of-interest analysis, the Ninth Circuit in *N.L.R.B.* v. *St. Francis Hospital of Lynwood*,[105] held that the Board had impermissibly established an irrebuttable presumption that a unit of registered nurses was appropriate and, further, that the Board's exclusion of proffered evidence regarding the appropriateness of an overall professional unit was contrary to the congressional admonition to avoid a proliferation of units in the health care industry. In addition, the court pointed out that the Board's use of the community-of-interest analysis in the health care industry was also contrary to the congressional admonition. Focusing on Senator Williams' statement, cited above, the Ninth Circuit pointed out:

> However, Senator Williams did not state that an examination of community of interests should be made or that it could justify a determination that a separate unit was appropriate. Rather, his statement was that "a notable *disparity of interests* between employees in different job classifications [emphasis added by the court]" could sometimes require a number of bargaining units. We view that language and the remaining legislative history of the 1974 amendments to the Act as requiring the Board to determine not the similarities among employees in the same job classification (indeed the fact that they share the same classification would inevitably led to the discovery of many similarities), but instead the "disparity of interests" among employee classifications which would prevent a combination of groups of employees into a single broader unit thereby minimizing unit proliferation. The congressional approval of the trend toward broader units in the health care industry indicates an awareness that the traditional factor of community of interests would be subordinated to the directive against undue proliferation. However, by including nonprofit hospitals within the Act, Congress sought to extend to hospital employees effective labor rights. By focusing upon the disparity of interests between employee groups which would prohibit or inhibit fair representation of employee interests, a balance can be made between the congressional directive and the employees' right to representation.[106]

[104] 239 NLRB at 875.
[105] 601 F.2d 404 (9th Cir. 1979).
[106] 601 F.2d at 419.

Subsequently, in *Newton-Wellesley Hospital*, 250 NLRB 409 (1980), the Board reconsidered its approach to registered nurse units in particular and health care units in general in light of the Ninth Circuit's *St. Francis* holding. Initially, the Board agreed with the court's conclusion that the Board had erroneously established an irrebuttable presumption in favor of the appropriateness of a registered nurse unit. Accordingly, the Board disavowed such a *per se* approach to unit determinations in the health care field. With regard to the Ninth Circuit's "disparity of interest" standard, however, the Board argued that the court's disagreement with the Board's approach "may be largely semantic" and "that the legislative history of the health care amendments clearly does not require the Board to forego a consideration of the community of interests among employees within the health care industry."[107] Utilizing the traditional community-of-interest approach, and focusing on the *similarities* existing among registered nurses rather than focusing on the *dissimilarities* between the registered nurses and that employer's other professional employees that might or might not have entitled them to separate representation, the Board reiterated its opinion first expressed in *Mercy Hospitals of Sacramento, Inc.*,[108] that nurses are entitled to separate representation.

However, the majority's *Newton-Wellesley* analysis fared no better in the courts than had the Board's previous attempts to formulate an acceptable approach to unit determinations in the health care industry.[109] Thus, the instant case was chosen as the new vehicle to set out the majority's views. Here, the majority once again dons sackcloth, pays verbal homage to the circuits, and undertakes a flawed analysis of legislative history and precedent, all in an effort to breathe new life into its approach to unit determinations in this unique industry. Initially, in response to the unrelenting chorus of court criticism, the majority admits that its decision in *Allegheny General Hospital* was "imprecise" and that judicial criticism has been "justif[ied]"; however, the majority does not disavow the underlying holding of that case. Instead of showing deference to congressional intent and undertaking a truly different approach to health care unit determinations, the majority merely trots out its threadbare reading of legislative intent and outlines the unit determination procedure that it has utilized since the passage

[107] *Newton-Wellesley Hospital*, 250 NLRB at 411–412 (1980).
[108] 224 NLRB 419 (1976), enforcement denied on other grounds 589 F.2d 968 (9th Cir. 1978), cert. denied 440 U.S. 910 (1979).
[109] See, for example, *Presbyterian/St. Luke's Medical Center*, the *en banc* decision in *Beth Israel Hospital and Geriatric Center, HMO International Hospital*, and *Frederick Memorial Hospital*, cited more fully in fn. 91, *supra*.

of the health care amendments. With regard to the disparity-of-interest analysis, the majority contends that Congress did not intend to change the Board's basic community-of-interest approach to unit determinations and that elements of the disparity-of-interest approach are encompassed by the community-of-interest test.

In brief, the majority argues that prior case law has identified a maximum of seven potentially appropriate units: physicians, registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees, and maintenance employees. The majority claims that:

> Only after determining that the unit sought fits one of these classifications do we then apply our traditional unit principles to determine whether the specific employees involve do, in fact, display the requisite community of interest to warrant separate representation. . . . If, however, petitioner seeks to represent a unit of employees smaller than one of these identified groups, for example, a unit consisting only of physical therapists or telephone operators, we will dismiss that petition before reaching the second stage of analysis, unless we are presented with extraordinary and compelling facts justifing allowance of a smaller unit.[110]

Apparently, the majority believes that this "two-tiered" approach to health care unit determinations satisfies Congress' admonition to avoid an undue proliferation of bargaining units and meets the courts' demand that the Board set out a logical and consistent rationale for its health care unit determinations.

I disagree that the majority's opinion reaches either of these objectives. In my view this "new" analysis has the intellectual underpinnings of a house of cards that amounts to little more than a rehash of the same old analysis that has been rejected by every circuit that has considered the issue.[111] On the one hand, the majority contends that it is enunciating a new health care unit determination test. On the other hand, it justifies that new test by relying on seven potentially appropriate units derived from a community-of-interest analysis that fails to take into consideration Congress' admonition against a proliferation of units.[112] Further, under the majority's two-tiered approach, a petition requesting a unit smaller than one of the seven designated units will be dismissed unless "extraordinary and compelling facts" are presented which justify the smaller unit. The majority contends that under such an analytical scheme, cases such as *Michael Reese Hospital and Medical Center*, 242 NLRB 322 (1979), where a unit of chauffeur drivers was found appropriate, will be the exception and not the rule. However, a fair reading of that case reveals no "extraordinary" or "compelling" facts that justify a separate unit and, despite the majority's assurances to the contrary, it is apparent that the so-called exceptional cases of today will, under the majority's analysis, become commonplace tomorrow.[113]

I am also troubled by the majority's finding of presumptively appropriate health care units.[114] Although it is clear that the Board is entitled to adopt presumptions, such presumptions are subject to judicial review "for consistency with the Act and for rationality."[115] "In order for the Board to utilize a presumption in this context, it must, at some prior occasion, articulate the bases for that presumption in a manner in which a court may review its propriety."[116] Other than explaining that Board precedent (based on an industrial community-of-interest standard) has established that these seven units represent groupings of employees commonly found at health care institutions, the majority offers no cogent rationale for settling on these seven units.

For example, the majority points out that it has refused to find appropriate a separate unit of pharmacists even though the pharmacists were physically isolated, had separate training and supervision, and had little contact or interchange with other employees.[117] Similarly, the majority refused to find appropriate a separate unit of switchboard operators, even though those employees were sepa-

[110] *Supra* at 1029. In addition to the seven listed potentially appropriate units, the majority has not disavowed its finding that boilerroom employees also constitute a separate and distinct appropriate unit, see, for example, *St. Vincent's Hospital*, 223 NLRB 638 (1976), enforcement denied 567 F.2d 588 (3d Cir. 1977). Also, Sec. 9(b) of the Act requires that a ninth unit of guards be given separate representation.

[111] See fn. 91, *supra*.

[112] *Allegheny General Hospital*, 239 NLRB at 873 and 875. I am in agreement with the discussion of precedent set out in the Chairman's dissenting opinion which points out that the traditional industrial community-of-interest analysis underlies the majority's health care unit determinations.

[113] I also find no merit in the majority's reliance on *Appalachian Regional Hospitals, Inc., Operator of June Buchanan Primary Care Center*, 233 NLRB 542 (1977), for the proposition that rather than finding more than seven units in exceptional cases, the Board more often finds fewer than seven units. In *Appalachian Regional Hospitals*, the union requested a wall-to-wall nonprofessional unit, and the case stands for nothing more than that even the majority does not find such a unit to be inappropriate.

[114] Although the majority asserts that the seven potentially appropriate units are not presumptions, a use of seven "starting points" certainly sounds like presumptions or at a minimum something akin to presumptions. See Weinsteins *Evidence*, vol. I, art. III, pars. 300[01]-300[03], and the definition of "presumption" set forth in Black's Law Dictionary Revised Fourth Edition.

[115] *Beth Israel Hospital* v. *N.L.R.B.*, 437 U.S. 483, 501 (1978).

[116] *St. Francis Hospital*, 601 F.2d at 416, fn. 14.

[117] *Kaiser Foundation Hospitals*, 219 NLRB 325 (1975).

rately supervised and had little contact with other employees.[118] There is no explanation, however, why, under its analysis, separate units of physicians and nurses are presumptively appropriate even though those professional employees share no more of a community of interest among their professions than the community of interest shared by pharmacists.[119] Similarly, there is no explanation why a unit of maintenance employees who have diverse job responsibilities, different lines of supervision, and extensive contact with other similarly skilled employees is presumptively appropriate, while, under the same analysis, the switchboard operators in *Duke University* were not entitled to separate representation.[120] As the Ninth Circuit in *St. Francis* pointed out,[121] it is obvious that employees sharing the same classification will have a commonality of interest, but Congress emphatically instructed the Board that something more than a commonality of interest is needed in fashioning health care units, because, otherwise, every work classification would constitute a presumptively appropriate unit.

In conclusion, I find no merit to the majority's contention that by adding a preliminary "screening" step to its unit determinations—establishing seven presumptively appropriate units—it has accepted Congress' directive to limit the number of bargaining units in the health care industry.[122] When the verbal chaff is culled from that analysis, it is clear that the majority's unit determinations focus on the commonality of interest shared among the employees in the requested unit rather than on the dissimilarities of interest those employees have with the health care employer's other employees. Such an approach does not accommodate Congress' direction to avoid a fragmentation of health care units and fails to meet the standards of review established by the Act and required by the courts. Accordingly, the majority's "new analysis" is deficient on its face.

II.

My approach to health care unit determination is based on the view that the legislative history bars the Board from applying its community-of-interest standard in making health care unit determinations. Initially, I note that the amendments themselves contain the unmistakable message that the health care industry is to be treated differently. Thus, as noted previously, the amendments curtail the right to engage in strikes and picketing, and establish special mediation and notice requirements for the health care field. Senator Taft best summarized his colleagues' views concerning the unique nature of health care in saying:

> It is important to remember that hospitals are not factories or retail establishments, and patients are not raw material or merchandise. Hospitals are for human beings and actions pursuant to this legislation must take this fact into account.[123]

Further, in directing that the Board avoid undue proliferation of bargaining units, Congress instructed the Board to examine the public interest in determining appropriate bargaining units.[124] As Senator Dominick pointed out: "The public interest . . . in the need for uninterrupted health care delivery at all times is paramount in considering legislation for bringing health care institutions under Federal labor relations law."[125] Accordingly, in

[118] *Duke University*, 217 NLRB 799 (1975).

[119] Arguably, under the majority's community-of-interest analysis, it would appear that the pharmacists in *Kaiser Foundation* were more deserving of a separate unit than are physicians and nurses.

[120] Again, under the majority's community-of-interest analysis, it would seem that the switchboard operators in *Duke University*, rather than the maintenance employees here, had more of a claim for separate representation.

[121] See fn. 106, *supra*.

[122] As I pointed out earlier, in addition to the enunciated seven units, Sec. 9(b) of the Act requires an eighth unit of guards, the majority finds a ninth unit of boilerroom operators, and, under the standards set forth in *Michael Reese, supra*, the majority easily will find additional units. On the basis of that number of units alone, the majority's analysis, which finds nine-plus units as a starting point, fails to consider Congress' concern with a proliferation of units. It is clear that that number of units creates the type of situation that Congress specifically instructed the Board to avoid, where wages are likely to leapfrog from contract negotiations to contract negotiations and strikes are more likely to occur and to interfere with the public's paramount interests in having uninterrupted access to health care. See *N.L.R.B.* v. *HMO International/California Medical Group*, 678 F.2d at 808. Unlike the majority, I would not find that nine or more units constitutes the norm for the health care industry, and I cannot envision finding that number of units unless *truly* exceptional record facts establish that that number of units is warranted. Indeed it is unlikely that one would find many *non*-health care employers, comparable in size to this hospital, who have been required to bargain in such a substantial number of separate units.

[123] Leg. Hist., *supra* at 116.

[124] In directing that the Board examine the public interest in determining appropriate bargaining units, both Senators Williams and Taft referred the Board to *N.L.R.B.* v. *Delaware-New Jersey Ferry Company*, 128 F.2d 130 (3d Cir. 1942), see fns. 100 and 101, *supra*. In that case, the Board had applied its traditional community-of-interest standards and found appropriate a unit of maritime employees that included both licensed ship officers and deckhands. (Prior to the Taft-Hartley amendments of 1947, supervisors were protected by the Act and could be included in the same unit as employees.) On petition for enforcement of the Board Order directing bargaining in that unit, the Third Circuit acknowledged that the Board's unit determinations are normally entitled to great deference. The court, however, refused to enforce the bargaining order because the Board's unit finding, in that case, had exceeded the limits of its administrative discretion. The court noted that the Board's traditional community-of-interest approach had failed to take into consideration the unique nature of the maritime industry and had ignored the public interest. In a similar fashion, the majority's adherence to a traditional community-of-interest standard in the health care industry ignores the public interest by failing to accommodate the special status accorded to the health care industry.

[125] Leg. Hist., *supra* at 142. In *St. Vincent's Hospital* v. *N.L.R.B.*, 567 F.2d at 592, the court defines the public interest as preventing unit "fragmentation in the health care field." See also *N.L.R.B.* v. *Mercy Hospital Association*, 606 F.2d 22, 27 (2d Cir. 1979), cert. denied 445 U.S. 971 (1980).

the context of this description of the public interest and of the congressional directive that the public interest is paramount and is best served by avoiding a proliferation of bargaining units, I agree with the Ninth Circuit's views expressed in its *St. Francis* decision that, in making unit determinations in the health care field, the Board must focus on the "disparity of interests" among health care employees rather than applying the "community of interests" standard that is applicable in other industries. Thus, when a petition is filed raising a question concerning representation among a group of health care employees, I will find that the requested unit is appropriate only where the record establishes that, because of a disparity of interest that prohibits fair and adequate representation, the requested employees are entitled to separate representation.[126] If the record fails to establish such a disparity of interest, I will dismiss the petition. As pointed out by the Tenth Circuit:

> It is not the similarity of employees' training, hours, conditions and activities which determine the appropriateness of the unit, it is, rather, the dissimilarity of interest relative to the collective bargaining process that determines which employees are not to be included in a proposed unit. The proper approach is to begin with a broad proposed unit and then exclude employees with disparate interests. One should not start with a narrow unit, such as registered nurses, and then add professionals with similar interests.[127]

III.

With regard to the record in the instant case, I generally agree with the facts as set forth by the majority; however, since I find that the majority's community-of-interest analysis is clearly at odds with congressional intent, I find it necessary to re-examine the record in order to determine whether the Union (the party seeking a narrower unit) has met its burden of establishing that the working conditions of the requested employees are so dissimilar from that of the Employer's other employees as to warrant finding that a separate maintenance unit is appropriate. As set forth more fully in the majority's opinion, the hospital is administratively divided into 90 departments and employs approximately 1,300 employees, including nearly 400 employees in various service departments and 39 employees in 4 maintenance departments. The Employer maintains centralized labor relations policies and personnel records for all of its employees, and a uniform system of discharges and discipline is administered throughout the facility.

With regard to wage rates and fringe benefits, the Employer has a separate wage and benefit plan for its 438 service and maintenance employees. As might be expected, individual pay rates are generally geared to the skills and training needed for the job. The skill level of the maintenance employees varies from several highly trained and licensed boiler operators to the unskilled positions of groundskeeper, refuse and linen collector, and maintenance helper. Accordingly, the pay rates of the maintenance employees range from the highest pay grades in the service and maintenance pay plan for the few highly skilled positions to a wide dispersion of pay grades for the other positions, which is similar to the dispersion of pay grades for the Employer's service employees.[128] Also, the record indicates there that there have been up to seven transfers (a nearly 20-percent rate) between the service departments and maintenance departments during the past several years.

As mentioned earlier, the 39 maintenance employees are administratively subdivided into 4 departments, and the nearly 400 service employees are similarly subdivided into a number of departments. Supervision for both the maintenance employees and service employees is structured along departmental lines, and there is as much a disparity regarding supervision between maintenance employees in different departments as there is between maintenance and service employees in different departments. Most of the maintenance employees work throughout the hospital spending 80 to 95 percent of their time working at the same work locations in close cooperation with the Employer's

[126] Although I agree generally with the Chairman's reading of congressional intent to avoid unit proliferation in the health care industry and with the view that a disparity-of-interest test is the proper approach to insure that end, I do not join the Chairman in finding that only two units are presumptively appropriate in this industry. Given the unique nature of the health care industry, and Congress' recognition of that fact, I am reluctant to apply any "presumptions" in determining appropriate units in this context.

I also agree with the Chairman that the majority is wrong and misstates the Legislative History when it asserts that Senator Taft's Bill S. 2292 which would have specified four appropriate units in health care institutions was "rejected" because it was "overly stringent." Initially, I must point out that Bill S. 2292 was never brought up for a vote, and, contrary to the assertion of the majority, it was not "rejected." It is clear that no legislative intent may properly be drawn from congressional inaction. *U.S.* v. *Price*, 361 U.S. 304 (1960). As the Ninth Circuit noted in *N.L.R.B.* v. *HMO International*, 678 F.2d at 808, in failing to inact Bill S. 2292, it is unclear whether Congress found the four units too broad, too narrow, or merely too rigid.

[127] *Presbyterian/St. Luke's Medical Center* v. *N.L.R.B.*, 563 F.2d at 457, fn. 6.

[128] Undisputed record evidence establishes that most of the maintenance work requiring extensive training and skills is contracted out to independent contractors because the Employer's maintenance employees do not have the background or training to undertake such work. Approximately one-half of the Employer's maintenance budget is allocated to hiring outside contractors to do the more highly skilled jobs.

other employees, and in particular with the service employees. Clearly, maintenance employees have substantial work contact with the Employer's other employees, and their work duties are closely integrated with that of the Employer's other employees and in particular with the service employees.

In sum, the general working conditions of the Employer's service and maintenance employees are very similar. However, in the enigmatic style that only it understands, the majority concludes that for the reasons set forth in its "imprecise" *Allegheny General Hospital* decision,[129] a separate unit of maintenance employees is warranted here. In doing so, however, it ignores or at least downplays certain critical factors. Thus, the majority points out that maintenance employees report to separate locations at the *beginning* of their shifts, but it fails to mention that most maintenance employees spend 80 to 95 percent of their time working throughout the hospital in close contact with the Employer's other employees. The majority also points out that maintenance department employees are separately supervised, but, again, it fails to mention that, since supervision is structured on a departmental basis, maintenance employees themselves are supervised separately from employees in other maintenance departments. The majority contends that maintenance employees have greater skills and experience than the Employer's service employees. However, the record establishes that only a few highly trained and licensed maintenance positions require significantly greater skills and experiences and that a substantial portion of the maintenance department positions are at essentially the same skill and experience level as positions in the service department. Finally, although the majority claims that maintenance employees do not share duties with service employees, it fails to note that the maintenance employees that do not share duties with service employees also do not share duties with maintenance employees in other maintenance departments. More importantly, a substantial proportion of maintenance employees work throughout the hospital, have extensive contact with other employees, and *do* share work duties with the Employer's other employees. Clearly, the work functions of a substantial portion of maintenance employees is closely integrated with that of the Employer's other employees.

To summarize, the record herein fails to establish a disparity of interest among the maintenance employees and the Employer's other employees sufficient to justify representation in a separate unit: (1) there is centralized control of labor relations and centralized control of personnel records; (2) there is a uniform system of discipline; (3) there is a common pay and benefit plan for maintenance and service employees; (4) the pay rates and general working conditions of a substantial proportion of maintenance employees are similar to the Employer's service employees; (5) the four maintenance departments are not an administratively distinct unit; (6) supervision for each of the four maintenance departments is structured in a fashion similar to the supervision of other departments; (7) there is extensive functional intergration between maintenance employees and other employees; (8) there is extensive work contact between maintenance employees and other employees at worksites throughout the hospital; (9) the skills and job functions of a substantial proportion of maintenance employees are very similar to those of other employees; and (10) given the size of the requested unit, there has been a significant number of transfers. Accordingly, based on the record before us in this case, it appears to me that even in terms of the majority's traditional community-of-interest standard, the majority has drawn the wrong inferences and reached the wrong conclusions in determining that a maintenance unit is appropriate. Therefore, I would dismiss the petition.

Finally, in closing, I must emphatically register my disappointment that this Board is no closer to establishing the unit framework that was intended by Congress to bring "a good collective-bargaining climate"[130] to the health care industry than it was when the amendments to the Act were passed in 1974. I do not understand my colleagues' apparent disregard for congressional direction and its apparent disdain for court criticism. Such an attitude can only have the effect of eroding public and judicial confidence in the Board's ability to fulfill the mission for which it was created. Unfortunately, the health care industry, health care employees, patients, and the general public will have to wait for yet another day for the stabilizing influence of the National Labor Relations Act to be brought to this industry.

[129] The majority finds that the maintenance employees involved herein are similar to the employees in *Faulkner Hospital*, 242 NLRB 47 (1979), and *Southern Baptist Hospitals, Inc.*, 242 NLRB 1329 (1979). In both of those cases, the Board found that separate maintenance units were appropriate "for the reasons set forth in *Allegheny General Hospital*."

[130] Leg. Hist., *supra* at 375, remarks of Senator Taft.